State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles Jesse Hull II 22, 2008 6:10 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13830 Esworthy Road Darnestown Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min 220-42-9964 Director 62 August 28, 1945 Pennsvlvania Usual Residence of Decedent 10b. County 10a State 10c City Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Maryland | Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13830 Esworthy Road 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 □ No
If Yes, Give 1963–1967
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investment Advisor Brokerage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice C. Yingling Ralph E. Hull ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13830 Esworthy Road, Darnestown, Maryland 20874 M. Teresa C. Hull/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 24, 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2008 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01360 Rockville, Inc. 300 West Prontgomer Rockville, Maryland 20850

Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Months disease or condition resulting in death) Brain Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed I physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. signed by the at be detached f 1 TYes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate perform 2**X** No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: : After this certifications in the section of the s Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2∑No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation n 24 hours after death le Funeral Director: Aft bletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) To the within 2. and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print DIV Year) State 31. Date filed (Month, Day, Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. In State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month JULY Day 22, 2008 **Physician** 07:22AM Esdras J. Hatcher /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min 243-26-6808 81 Yrs. Director July 16, 1927 North Carolina Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other then "nature!", or items 23a or 28a-f shov event, the "scical Eventing round by notified a Maryland Baltimore 1 ☐Yes 2 No Director Baltimore the 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 9408 Avondale Road 21234 America Funeral of death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. white ≥ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) d 2 should be filed w. th and Mental Hygier 7 is marked other th Railroad 8 Brakeman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Marshall Hatcher Ruth callahan ျှ reumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 19a. Informant's Name/Relationship (Type. Print) permit. Peges 1 end 2 s
Department of Health ar
Important: If item 27 is
eny injury or other treu R. Ellen Hatcher/ daughter 6216 East Hemlock Drive Eldersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory of other place)
Evans Funeral
Chapel-Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 23, 4 ☐ Donation 5 ☐ Other (Specify) 2008 Forest Hill, Maryland 21. Signal of Funeral Service License Pederul dancer atives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed physiclen and s the buriai-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical es ettending p nse (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the e P.0. 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown DYSRHYTHMIA Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy The perform certificate 2 No 1 □Yes 2 No 1 ☐ Yes Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) uly 22, 200 8 XI D46356 30. Name any address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar TABASSI

2 5 2008

<u>KHOSROW</u>

31. Date filed (Month, Day, Year)

M.D.

32, egistrar's Signature

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 24003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JOAN ELIZABETH HAMPER JULY 2008 6:35^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore 5816 N. Hazelwood Avenue Baltimore County If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number Date of Birth (Month, Day, Year) June 20,1935 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X X 73 213-36-2391 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, it e Medical Examinsar must be rediffied at once. 1 TYes XXNo Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5816 N. Hazelwood Avenue USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 🏖 🖳 Married 21215-0036 1 □Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Homemaker Homemaking →Own Home **Baltimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph P. Hoffman Julia Vogt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl T. Hamper (Husband) 5816 N. Hazelwood Avenue Baltimore, Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem: 7-26-2008 Baltimore, Md. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANCREATIC disease or condition resulting in death) /Medical bue to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by THROMBOSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe HYPERLIPIDEMIA 1 ☐Yes 2 No 25. Was ase referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State

29b. Signature and title of certifier

30. Name and add

31. Date filed (Month

P.O.

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Registrar

DRIVE SUITE 312 TOWSON, MD 21204

ss of person who completed cause of death (Item 23a) (Type, Print)

505 OSLER

32. Paristrar's Signature

MD

5 2008

Year)

State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Physician Hensler July 22, 6:05 PM Deborah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City 6909 Eastbrook Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Hours Min. Months Days 1 □ M 2 🕱 F 24,1956 52 January Director 220-68-0818 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Ite Modical Examinatment be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Baltimore City N/A 1 ☐ Yes 2 ☐ No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 6905 Gough Street U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 If Yes, Give 1 Never Married 2XXMarried 21215-0036 White 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Office Worker 12 yr's 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be William Hall Collins 5 4 1 Florence မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry A. Hensler - Husband Baltimore, MD 21224 6905 Gough Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KK remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/08 Towson, MD Hilltop Service 21. Signature of Funeral Service Lices 22. Name and Address of Facility Baltimore, Maryland 21222 an Plankon Duda-Ruck Funeral Home, Inc. 7922 Wise Avenue 23a. Part 1. Enter the disease, or complications that caused of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician VIETHSTATIC NEURO ENDOCUNE disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes 2 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) SISTER'S 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this RESIDENCE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 4D D0066507 23,2008 KYSICIAN GREENE STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

P.O.

Records.

Vital

of

Division

UNIVERSITY

OF

2. Registrar's Signature

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31. Date filed (Month, Day, Year)

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21201

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State Registrar Donna M. Vincenti, MD

31. Date files (Mogh, Bay 2008

111 Penn Street, Baltimore, MD 21201

32. Registraris Signatu

Assistant Medical Examiner

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items of Parparated Parament of the East and Trends of Parament of the East And Trends of Parament of the East And Trends of

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 5:01 Wilmer Paul Henderson Julv 18 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Bel Air 6. Sex 1 1 1 M 2 □ F Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1915 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 214-05-3078 MD Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 1 □Yes 2 No Director MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number W. Ring Factory Rd. Apt. 1123 21014 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. In mportant: If item 27 is marked other than "natural", or iten any lipiny or other traumatic event, the Medical Evanturanonce. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) U.S. Government Elementary/Secondary (0-12) Chemical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett Biddle George Henderson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a **Lynn Davies Daughter**Bruce Henderson/Son 807 N. Pine Ridge Ct. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 23, Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A 8717 Green Pastures Dr. Towson MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) my, carpia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certifical filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Sytursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Kcrtifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/24/08 D3229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 5 2008 Registrar

Physician /Medical Examiner Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- State of Marylan	•	artment of H		and M		ene g. No 20	08 24007
an	1. Decedent's Name (First, Middle, Last)	He	yman			2. Date of Death		3. Time of Death
al er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Baltimore		f Death		4c. County	of Death
	5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 1 ☐ M 2 🛣 F 81	last birthday) Yrs.	if Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth Month Day 1	927	9. Birthplace (State or Foreign Country) FL
ō	Usual Residence of Decedent	y, Town or Loc	cation IMORE					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
Director	10e. Street and Number	DALI	10f. Zip-Code			10	g. Citizen of W	
ra D	3409 OLD POST DRIVE		21	.208			USA	Α
Funeral	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U. Armed Forces? 1 □ Ves ≥∑ No	S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- lican, etc.)		e - American Indian, k, White, etc.
þ	1 ☐ Never Married 2		I∐Yes 2∏∏No	Specify:			Specify	T T A A A A A A A A A A A A A A A A A A
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired,	luring most	of workir	ng 1	6b. Kind of Bu	usiness/Industry
Com	4	HOM	EMAKER					N HOME
To Be	17. Father's Name (First, Middle, Last) EDWARD AARON	BELAGA			r's Name LANCI	(First, Middle, N HE		HREIBER
_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street					
	CHARLES HEYMAN / HUSBAND 20a. Method of Disposition 20b. F		OLD POST	DRIV		ALTIMORE 2		1208 City or Town, State
	Burial 2 Cremation 3 Removal from State	emetery, cren	natory or other place	e) .				LSTOWN, MD
	21. Signature of Funeral Service Densee	/ 22	Name and Address		- 2011	LEVINS		ROS. INC.
	23a Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line							Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	denos	1					Onset and Death
	Due to (or as a conseq	uence of):						
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):						
Exal	that initiated events resulting in death) Last C Due to (or as a conseq	uence of):						
dical	d							
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnance Other (specify)	′				te of delivery onth Day Year
ed by Pł	Part II. Other significant conditions contributing to death but not res	sulting in the u	ınderlying cause gi	en in Part	I.	23e. Did tob		tribute to the cause of death? 3 Probably 4 Unknown
Completed by						24a. Was an autopsy perform	/	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?		Othe	NF:		(Check only one		
n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of Injury	1 3 DOA	at All Nu	rsing Hon	ne 5 Resider 28d. Describe ho		ner (Specify)
catio	2 Accident investigation		M 1 🗆	.r Yes 2 □ I				
Certification:	4 Homicide determined 28e. Place of injury - At he building, etc. (Specify		eet, factory, office		2	28f. Location (St City or Town,		ber or Rural Route Number,
Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my kno and manner stated.	wiedge, death tion and/or in	occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a	and due to the ca ed at the time, d	ause(s) and mate and place,	anner as stated. , and due to the cause(s)
Me	29b. Signature and title of contrier MD		29c. License ReS	number	٥	29	7/2	d (Month, Day, Year)
	30. Name and address of person who completed cause of death (Iter		Print)		600 N	lorth Wol	fe St, Ba	altimore, MD, 21287
te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	٧					

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DHMH 17 Rev 1/2001

Sta Regist

			For State Registrar	State of	Marylan	-	artmen rtificat			and M		giene Reg. No. 2	2008	24008
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> WILLIAM	HIRS	HFIELD						2. Date of De Month JULY	22 22	2008	3. Time of Death 7:15 A M
	Examir		4a. Facility Name (If not institution MILFORD MANO)	R NURSING	HOME			TIMO	Location (O Date of Bir	BA	ALTIMOR	E
	Funeral Director		5. Social Security Number 238-12-8216 Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age <i>(In yr</i> s. i 93	Yrs.	Months	Days	Hours	Min.	8. Date of Bir 12/25	7191 4	Co.	hplace (State or Foreign untry) NC
	e Maryland 3a-f show	Director	10a. State 10b. County MD BAL	TIMORE	10c. City	y, Town or Lo BALT	cation IMORE							10d. Inside City Limits 1 ☐ Yes 2 No
	h with th	al Dire	10e. Street and Number 4204 OLD MILF	ORD MILL R	D.		10f. Zip		1208			10g. Citize	en of What Co USA	untry?
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Experimer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☑ Widowed 4 □ Divorced	If Ves Giv	ces? 2 X No e		Was Deced If Yes, spec 1 □Yes		spanic Or n, Mexical Specify:		ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: W	rican Indian, p, etc. HITE
21215-0036	filed within 72 ho Hygiene. other than "natu ant, the Medical	Completed by	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-	4or 5+)	l	dent's Usua kind of wo DO NOT us ROPRI	rk done d se retired	luring mos ')	at of work	ing		d of Business/	AGENCY
yland	2 should be filed and Mental Hy is marked othe aumatic event,	To Be C	17. Father's Name (First, Middle, JOSEPH		SHFIEL				R/	ACHEI		A	DLER	
, Mar	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relations LINDA RICH	hip (Type, Print) DAUGHTER		19b. Mailii 3900	ng Address CITY	(Street a	UE,	#D20	al Route Numb 5 PHIL	er, City or ADFLP	Town, State, 2 HIA, P.	Ä 19131
Baltimore, Maryland	permit. Pages 1 ar Department of Hee Important: If item : any injury or other once.		20a. Method of Disposition X Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		20b. P	Place of Dispo	psition (Nar matery or o	ne of the Colac IEN	ÈM.		Date /2008		ation - City or MORE,	
Balt	permit. Departi Imports any inj		21. Signature of Funeral Service	Licensee			2. Name ar 3900 F				L LEVIN ROAD F			MD 21208
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aND-	tused the death tich line. SHAGE or as a consequ	Al3h						arrest,		Approximate Interval Between Onset and Death
8760,		al Examiner	Sequentially list conditions, any first immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last	c	or as a consequence as a consequence									
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 🗀 Feta ant at time of d	I death 3	⊒ Ectopic p ⊒ Other <i>(sp</i>		ý			2.	3d. Date of de Month	livery Day Year
ds, P.	uires that signed b ld be deta	by	Part II. Other significant conditi	ons contributing to de	ath but not resi	ulting in the u	inderlying o	ause give	en in Part	l.		tobacco us		the cause of death?
Vital Records,	i lcian: The law requir certificate has been s ector, page 2 should	Completed									1 □ Yes	opsy ormed? 2 ☑ No	24b. Were as prior to death?	utopsy findings available completion of cause of
Division of Vit	ng Phys ffer this meral dir	Certification: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	h, Day, Year)	28b. Time o Injury	of A	28c. Injur Work 1 □	er: 4 🗖 N	ursing Ho	th (Check only ome 5 Res 28d. Describe	sidence 6 how injury	occurred	
Divi	ipital or At ours after d eral Direct filled in by		4 ☐ Homicide determ	28e. Place	of Injury - At hong, etc. (Specif	5y)			me date a	and place	City or To	iwn, State)		ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		Examiner: On the ba and mann	asis of examina		nvestigation	n, in my o		ath occu	rred at the time	e, date and 29d. Date		e to the cause(s)
	70		30. Name and address of person		e of death (Item 25 MG	n 23a) (Type,	Print) SUITE							136.
	Sta Registi		31. Date filed (Month, Day, Year)	32. Ro	egistrar's Signa		N)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar	•	partment of ertificate o	Health and N of Death	, ,	iene •9. No.2 () () 8	24009
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edward H. Ike	ena Jr.				2. Date of Deat Month July 2	^h Day 12008	3. Time of Death 2:15a _M
>	Examir Funeral	ner	4a. Facility Name (If not institution, give stre Heritage Nursir 5. Social Security Number 6. Sex 722-05-5294	ng Cente	In yrs. last birthd	Bal		8. Date of Birth (Month, Day,	Year) 9. Birth	timore splace (State or Foreign untry)
	Director		Usual Residence of Decedent		80 Yrs	•		Oct. 9		MD 10d. Inside City Limits
	the Mary 28a-f sh notifled	Director	MD Baltimor	re		Esse:		10	0g. Citizen of What Co	1 □Yes 2 X No
	death with the Maryland ms 23a or 28a-f show r must be notifled at	Funeral Di	519 Virginia Av	Venue Was Decedent Eve	arin IIS 1	21:	221		USA	
-0030	72 hours after d natural", or Iten dical Examiner	ğ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces?		If Yes, specify C	of Hispanic Origin? (S cubaŋ, Mexican, Puert No <i>Specify:</i>	o Rican, etc.)	Black, White	
7-017	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educati (Specify only highest grade or Elementary/Secondary (0-12)	College (1-4or 5+)	- (G lif		cupation ne during most of wor lired) lectricia	king	16b. Kind of Business/I	•
7 011	buld be filed within Mental Hygiene. arked other than " atic event, the Men	Be	17. Father's Name (First, Middle, Last)	2yrs	11111	crare B.	18. Mother's Nam	ne (First, Middle, M	Maiden Surname)	ice
<u> </u>	should be nd Mental marked c	ဥ	Edward H. Iken		1401.40			Strec		
<u> </u>	and 2 sho salth and n 27 is mi		19a. Informant's Name/Relationship (<i>Type.</i> Mary Patricia Bl	,]				, City or Town, State, 2	•
altillore,	Pages 1 and 2 nent of Health int: if Item 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Di- cemetery, of	sposition (Name of crematory or other p	i	Date	timore MD 20c. Location - City or Baltimor	Town, State
Dall	permit. Page Department of Important: If any Injury or once.		21. Signature of Funera Service Licensee	mul	Ch	22. Name and Add		300 Mace	e Ave. Ba of Essex	lto. MD 21221
4	Physician /Medical Examiner	er.	23a. Pa.1. Enter the disease, or sent loat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ions that caused the cause on each line. Due to (or as a control of the control	ARY consequence of):				y DISEAS	Approximate Interval Between Onset and Death
,00,00	Othe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DE M	KIL	NEY	DISEKS	SE		
.O. DOX	the death certi by the attending ached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Feta! death	3□Ectopic pregna 5□ Other (specify,			23d. Date of deli Month	very Day Year
r con	w requires that been signed be should be deta	by	Part II. Other significant conditions contrib	outing to death but r	not resulting in the	e underlying cause	given in Part I.	23e. Did tot	pacco use contribute to es 2 □ No 3 □ Pro	
ייים ווייים	: The law n cate has be page 2 sho	Completed	/					24a. Was a autops perfor 1 Yes	prior to c	topsy findings available completion of cause of
) 	sician certifi rector	Be	25. Was case referred to medical examiner?	oital:			26. Place of Dea	th (Check only on	e)	
5	g Phy er this eral di	7: To	, [] 163 2 40	28a. Date of Injury	2 ER/Outpa	tient 3 DOA	4 Nursing H njury at Vork?		ence 6 Other (Spec	cify)
NISION I	r Attending Physician: The laver death. rector: After this certificate has by the funeral director, page 2 is by the funeral director, page 2.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Y 28e. Place of injury building, etc. (- At home, farm,	M 1	☐ Yes 2☐ No	28f. Location (St City or Town	reet and Number or Ru	ural Route Number,
ב	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	: On the basis of e	kamination and/o	eath occurred at the r investigation, in m	e time, date and place ny opinion, death occu	, and due to the c		stated. to the cause(s)
	To the within to the comple	Mec	29b. Signature and title of certifier	and manner state	1. (1)		ense number		9d. Date signed (Monti	
) Sta	- 1	30 N me and address of person who comp 31. Date filed (Month, Day, Year)	leted cause of deal	male	pe, Print) P(C	iu Di	indea	7-24-	1222
Ē	Registr	ar	JUL 2 5 2008	A HORA	19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Pay 200 **Physician** 2:15AM INSOY mo WIY /Medical 4b. City, Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner medica Burn Anne Nashenst Center Rmore 10 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months 1 □ M 2 🗹 F -30-566 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wordal Event in at the notified at once. 1 ☐ Yes 🎾 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 210 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paren ites caren los 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be vees U illiams noval ဥ 19a. Thjormant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rimatore 22/ Name and Address decility of Funeral Service Licensee 21229 Part . Ente the dis shoo , or eart fair ediate ~ se (Final ase or condition base, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ardiovescular Disease Examiner therus clevol if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown P contribute to the cause of death? þ 4 🗹 Unknown 3 Probably Completed 4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 2 Be Certification: To Other (Specify) 2 curred

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, & Division of Vital Records,

Maryland 21215-0036

Baltimore,

インクロン

attending physician and for use as the burial-tran signed by the a icate has been sli ; page 2 should b certificate director this After this funeral c To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

art II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deal
Diahetes	Mellitus	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkr
Myreste	NSION	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
5. Was case referred to medical		12.00
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

^{Year)} 2008

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (litera 23a) (Type, Print) Hospital Drive, Glen Burnie, VUICE 31. Date filed (Month, Day Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

(Check only

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 25

2008

egistrar's Signature

Baltimore, Maryland 21215-0036

			For State Registrar		State of	Maryland		artment of H rtificate of I			ıl Hygie Reg	ne . №2 0 0	8	24012
ı	Physici /Medic		1. Decedent's Name	e (First, Middle, L	ast)	\rabe\/	, 5	nochho		2. Date	e of Death		ear 00%	3. Time of Death
	Examin		4a. Facility Name (/	f not institution, g	ive street and nun	nber)		4b. City, Town, or	Location	of Death	1	4c. County of	Death	
					uture Care-			If Under 1 Year	If Under	Baltimore	e of Birth		N	
ı	Funeral Director		5. Social Security N	-5271	Sex 1□M 2□F	7. Age (In yrs. le	Yrs.	Months Days	Hours	Min. (Mo	onth, Day, Y Jan 14,	'ear)	Coun	ace (State or Foreign try) Maryland
)	and w		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ecation					10	Od. Inside City Limits
1	Maryl f sho ied a	ō	Maryland	R	altimore			F	Baltimor	re				1 De Yes 2 De No
3	r 28a	Director	10e. Street and Nu	L	alumore .			10f. Zip Code			100	. Citizen of Wh	at Coun	try?
3	h with		3427 Edo	rest Road					21	244			U.S.	A.
2	deat	Funeral	11. Marital Status		12. Was Dece Armed Fo	dent Ever in U.S	5. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Or	rigin? (Specify Ye	s or No-	14. Race -	America White,	
5-0036	be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Marr 3 □ Widowed	ied 2□ Married 4□Divorced	1 ☐ Yes If Yes, Giv Year or Da	2□No e X		1 □ Yes 2 □ No	Specify		,	Specify:	·	Black
2 0	72 ho natur lical I	ed	(Spec	15. Decedent's l	Education		16a. Dece	dent's Usual Occup	ation	st of working	16	6b. Kind of Busi	ness/Inc	dustry
<u>کے کہ</u>	ithin an ".	Completed	Elementary/Seco		College (1	-4or 5+)	life.	kind of work done of DO NOT use retired				(Own H	lome
	filed withi Hygiene. other than ent, the M		12	(First Mindale I a	-4\			Hoi	memak	(er ner's Name (First,	Middle M			
Maryland	4 5 5 to	Be	17. Father's Name		rd Braxton				IO. WOUL	iers warne (riist,		n Winnard		
<u></u>	2 should be f and Mental I is marked of aumatic eve	၉	19a. Informant's N				19h Maiti	ng Address (Street	and Numb	her or Bural Boute				Code)
Σ	nd 2 s lith an 27 is trau		Doreen C	·	(Type: Tring			3427 Edcrest			•		, <u></u> p	2000)
<u> </u>	ages 1 and 2 should b nt of Health and Ment i: If Item 27 is marked r or other traumatic e		20a. Method of Disp	_		20b. Pl	ace of Dispo	sition (Name of	í	Date		c. Location - C	ity or To	wn, State
OE .	Pages nent of I int: If Ite			☐Cremation 3 5 ☐ Other (Spec	☐Removal from :	State		matory or other plac	1	07/2	4/08	Ba	ltimor	e, Md.
Baltimore,	permit. Pages : Department of H Important: If Ite any injury or ot	Ιí	21. Signature of Fu		2	-		estern Ceme 2. Name and Addre			,			,
ä	a m Pe		Tka	1101	Ih	Ston	7	Estep I 1300 E ter the mode of dyir	Brother	rs Funeral So	ervice,	P.A.		
			23a. Part1. Enter t	the disease, or co	mplications that c	aused the death ach line.	Do not en	ter the mode of dyir	ng, such as	s cardiac or respi	ratory arres	z 12 17		Approximate Interval Between
	Physician		Immediate Cause	(Final		1	J-nh	roscleve	7513				1	Onset and Death
	/Medical		resulting in death)		Due to (or as a consequ								7
- 6	Examiner		Sequentially list co	enditions.	b								_	
. /	pe tis	ine	cause. Enter Under Cause (Disease or	erlying	Dus to (от ая в пипянци	iones of):						1	
V	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death)	S I	c	or as a consequ	ience of):					- *	_	
58760,	sician buria	alE												
687	ificate g phy- as the	edical			d		_							
Box	death certific attending pl	Physician/M	IF FEMALE: 23b. Was deceden	it pregnant		come pf pregna: irth 2 ☐ Fetal		□Ectopic pregnancy				23d. Date	of delive	*
.0	deatl	icia	in the past 12 1 ☐ Yes 2	months?		ant at time of de		Other (specify)	y 			Mont	h	Day Year
P.O.	at the by th	چ	9 Unknown											
Ś	es th igned be de	þ	Part II. Other signi	ficant conditions	contributing to de	eath but not resu	Ilting in the u	nderlying cause giv	en in Part	1. 23				ne cause of death?
ord	requir een s nould	ted		-							I L Yes	s 2 12 No 3	S L Prot	oably 4 □Unknown
or Vital Records,	e law nas b	Completed								24	la. Was an autopsy	pr	ior to co	psy findings available mpletion of cause of
E E	: The cate to page	Col								1[perform Yes 2		ath? Yes	2□ No
Vit	Ician certifi ector	Be	25. Was case referexaminer?		Hospital:			ot 3 DOA Oth		ce of Death (Chec				
ō	Phys this ral dir	2	1 ☐ Yes 2 ☐ 27. Manner of Dear	311	28a. Date		ER/Outpatie 28b. Time o	III 3 DOA	4 5 N	Jursing Home 5		ce 6 Other		(y)
no	ding J. After funer	ion	1 🔂 Natural	5 ☐ Pending investigati	(Mon:	th, Day Year)	Injury	Wor	k? Yes 2□		CSCIDE HOV	v injury occurre	u	
Division	Atten deatl ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not determine	be 28e. Place	of injury - At ho	me, farm, st	reet, factory, office		28f. Lo	cation (Stre	eet and Numbe	r or Rura	al Route Number,
Š	afor after	Certification:	4 ☐ Homicide	determine	buildi	ng, etc. (Specify	()			Cit	ty or Town,	State)		
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)		aminer: On the b			th occurred at the tinvestigation, in my						
	Fo the vithin Fo the complex c	Me	29b. Signature and	title of certifier	5			29c. Licens	e number	1	29	d. Date signed	(Month,	Day, Year)
						_	\bigcirc	1	737:	213		JUH!	22,	८०० इ
	lo		30. Name and add	ress of person wh	o completed caus		23a) (Type	Print)	Ce to	enten	MP	2113		-
	Sta Registi		31. Date filed (Mor	nth, Day, Year)		egistrar's Signa		nells	. 50011		, ., ,	Cito		
				~= ~ .		- Albert - Oh. c								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 10:38 PM Joseph John Knott 2008 JUU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ^cExaminer City Sinai Hospital of Baltimore Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 X M 2 □ F 213 28 4545 77 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and proce. Director Maryland Harford 1 ☐ Yes 2 X No Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3821 Prospect Rd. 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No
If Yes, Give Korean
Year or Dates. War 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White <u>۾</u> 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Ship Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Knott Sophia Knauer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Loir McDaniel (Son In Law) 3823 Prospect Rd. Street, Maryland 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Gardens Of Faith Cemetery July 28,2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 W. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final infarction **Physician** Myocardial hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** neavs Cormany artery Sequentially list conditions, Cilia to (or ซะ ซ ซอกรส์ตุ้นอกซอ of): Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 😿 attending physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ os smetru monan 1 Ves 2 No 3 Probably 4 Unknown Completed chronic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **L**No 1 □ Yes 2 **D**No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 LINO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 JULY, 22, 2008 30. Name an address person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SINAI HOSPITAL OF 32. Registrar's Signature 2008 Registrar CARCAR.

DHMH 17 Rev 1/2001

JOSEPH

KNOTT

ORIGINAL

08-05540 Thomas Kikas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24014

			- For State	Certi	ficate of	Death			Reg.	No.	00 2401
	Physicia	an/	Decedent's Name (First, Middle,Last)						Date of Death Month	ay Year	3. Time of Death 2350 hrs
redica	l Exami		Thomas W. Kikas,		14	o. City, Town, c	r Logetian of		July 19, 200	4c. County of Dea	
			4a. Facility Name (if not institution, give s Baltimore Washington Medi		4"	Glen Burni		Death		Anne Arunde	
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Ye		24Hrs.	8. Date of Birth((MM/DD/YYYY) 9. B	
	irector		212-25-3248	1 2 F 19	Yrs.	Months Da	ys Hours	Min.	Oct. 1	5, 1988 C	Country) Maryland
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	n				-	10d. Inside City Limits
-	*		Maryland Baltimo	ore Mic	ddle Ri	ver					1 Yes 2 XX
	daryland 28a-f show I at once,	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of What Co	ountry?
	the M a or 2 tiffed	ä	303 Lambison Cour	ct		2122	0		U	nited Sta	tes
	death with the Maryland or items 23a or 28a-f she must be notified at once	Funeral		12. Was Decedent Ever in U.S Armed Forces?		Decedent of H				14. Race - Am White, etc.	erican Indian, Black,
	or ite	핊	1 X Never Married 2 Married	1 Yes 2 X No	1	Yes 2 X N	lo encome			Specify: W	hite
	rs afte ural", miner	à.	Widowed 4 Divorced 15. Decedent's Education (Specify online)	f Yes, Give Year or Dates: v highest grade completed)		's Usual Occup		ind of wo	rk done	16b. Kind of Busines	
	d be filed within 72 hours a fental Hygiene. narked other than "natura event, the M dical Examir	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working li					
036	within 72 jene. ner than Medical	du		+2	Electi	ician "				Construc	tion
5-0036	Hygie Hygie othei		17. Father's Name (First, Middle, Last)					,		aiden Surname)	
121	d be fi ental l arked	Be	Thomas Kikas, Sr		T 40h Mailine	Address (St	Miche			per, City or Town, Sta	ate Zin Code)
D 21	2 should be filed within 72 hours after hand Mental Hygiene. 27 is marked other than "natural", o maric event, the Medical Examiner 1	٤	19a. Informant's Name/Relationship (Ty		ű.						1
, MD	and 2 lealth tem 2 traun		Michele Kikas (1 20a. Method of Disposition		ace of Disposi	tion (Name of	n Cour cemetery,	T M	Date R	20c. Location - City	or Town, State
Baltimore,	permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 Burial 2 Cremation 3	Removal from States	ematory or oth		Cana	7/25	/2000	Middle E	N Novice
lfi.	uit., Pa artmer ortan		4 Donation 5 Other Specify: 21. Signature of Funeral Service 1998	/HOT		ame and Addre			72008 1	MIddle F	River, Md.
Ва	Dep.		IVINAL ON	An All	Dı	ida-Ruc	k Fune	ral	Home of	Dundalk,	Inc.
, Ph	ysician		23a. Part I. Enter the disease, or complifailure. List only one cause on each	cations that caused the seath.	Do not enter the	ie mode of dyil	ng, sach as ca	ardiac or	espiratory air 6	sir, shock, or heart	Approximate Interval Between Onset and
	Medical caminer	4		Electrocution							Death
•	ammer		or condition resulting in death)	oue to (or as a consequence of)):						
		-	Sequentially list conditions, if any, leading to immediate	Oue to (or as a consequence of)):						
		Examine	cause. Enter Underlying Cause								
	ed nsit	Exa	events resulting in death) Last d.	Due to (or as a consequence of)):						
	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	UNPENDED	AMENDED				-			
760,	ate be hysici e buri	Medica	IF FEMALE:	23c. If yes, outcome of pregn	nancy					23d. Date of deli	very
687	ertific ding p e as th		23b. Was decedent pregnant in the past 12 months?	1 Live birth		tal death	3 Ectopio	c pregnar	псу	Month	Day Year
Box	leath certific e attending p for use as th	Physician	1 Yes 2 No 9 Unknown	Pregnant at time of dea	atn 5 Ot	her (Specify)					
B	t the de by the ached f		Part II. Other significant conditions		sulting in the u	inderlying caus	se given in Pa	art I.			e to the cause of death?
P.0	vian: The law requires that the certificate has been signed by ector, page 2 should be detach	d b							1 Yes	2 No 3	Probably 4 V Unknown
of Vital Records,	requir been s hould	Completed							24a. Was a		e autopsy findings available to completion of cause of
000	te has ge 2 sl	直								med? deat	
ž	nt: The rtificate or, page		25. Was case referred to medical			26.PI	ace of Death	(Check c	only one)		
Vita	ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing	g Home 5	Residence 6 0	Other:
ō	ding Phy After the funeral	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jul 19, 2008	28b. Time of 2153 hrs		Injury at Work	- 19		now injury occurred strocuted at wor	rk
ion	tend death tor: y the f	atio	1 Natural 5 Pending 2 ✓ Accident Investigation	on			Yes 2				Dural Davida Number City
Division	ipital or Atteno ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not determined			et, factory, offic	ce building, et	- 1	or Town S	Street and Number of State) Id Drive, Severna	or Rural Route Number, City
	Hospital or A 24 hours after Funeral Dire		4 Homicide	an: To the best of my knowledge		rod at the time	data and ni				
	To the Hospital within 24 hours To the Funeral completely filled	Medical		On the basis of examination a	ge, dealifoccu nd/or investiga	ition, in my opir	nion, death o	ocurred a	t the time, date	and place, and due	to the cause(s)
A	To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			ense number				(Month, Day, Year)
			1/1 1111	1 -1-		0.	.C.M.E.	00	OME	July 20, 2008	3
	4		30. Name and address of person who	completed cause of death (Item	23a)						
			Theodore M. King, Jr., MD			111 Penn	Street, Ba	altimore	e, MD 2120 ⁻	1 	
	Regi		31. Date filed (Month, Day, Year) 25	32. Registrar's Signatu	F 60	de					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2008 24016
State of Maryland / Department of Health and Mental Hygiene

¢ %		1- For State Registrar	Certificate of D		Reg	No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)	AWSON		2. Date of Death	lav Year	3 Time of Death 2045 hrs
		4a. Facility Name (if not institution, give street and not all 16 Check	umber) 4b. (City, Town, or Location of Deat		4c. County of Death	ila
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday) If	Under 1 Year If Under 24Hr	s. 8. Date of Birth(I		Hplace (State or
Director		212-42-5855 1 M 2 F Usual Residence of Decedent	64 Yrs.	Ionths Days Hours Min	09-25	-1943 Foreig	untry) M D
land f show any once.	tor	10a. State 10b. County A	10c. City, Town or Location	Tmore			10d Inside City Limits 1 Yes 2 No
th the Mary 23a or 28a- notified at	I Director	3116 Chester	ield Are 10	Z 1213	10g.	Citizen of What Cour	itry?
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed F 1 Yes 3 Widowed 4 Divorced If Yes, Give Ye	forces? If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerton 2 No specify		14. Race - Ameri White, etc.	can Indian, Black,
hours al natural	ed by	15. Decedent's Education (Specify only highest gra	ide completed) 16a. Decedent's U	sual Occupation (Give kind of f working life. DO NOT use re		6b Kind of Business/I	ndustry
1036 vithin 72 ene. er than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Warel	vouse Mai	$^{\circ}$	FurniT	ure
D 21215-0036 should be filed within 7 and Mental Hygiens 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last) A 1 B ERT (AWSON)	Sr	18. Mother's Nam	e (First, Middle, Mai	den Surname)	
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tingury or other traumatic event, the Med	To		Nife 316	Chester fel	D Ave. 1	B2170,1	m 31713
Baltimore, permit Pages I a Department of He Important: If ite		20e Method of Disposition 1 Burial 2 Cremation 3 Removal f	()		Date 2	20c. Location - City or	Town, State
Baltir permit Departm Importa	,	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		and Address of Facility	Dweiz?	Funeral	Home
Physician /M		23a. Part I. Enter the disease, or complications that of failure. List only one cause on each line	caused the death. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest.	, shock, or heart	Approximate Interval Between Onset and
Examiner		or possible assemble in death?	ive Atherosclerotic Cardiova a consequence of):	scular Disease			Death
	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	a consequence of):				
111/2 =	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as:	a consequence of):				
760, Trate be executed the burial - transit	ical E	d	T. #4	/0 /00 ===			
760, icate be physicia	= 1	IF FEMALE: 23c. If yes,	Item#4a,perME,G882,8 outcome of pregnancy	/8/08,WS		23d Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician	1 Ves 2 No 9 Heknown	nant at time of death 5 Other	eath 3 Ectopic pregn (Specify)	ancy	Month E	Day Year
D.O. Bothat the dended by the	Phy		o death but not resulting in the unde	lying cause given in Part I.	23e. Did toba	c∞ use contribute to	the cause of death?
S, P.C juires that n signed l	ed by	-	·····		1 Yes		ably 4 Unknown
e law requir e has been s ge 2 should	Completed				24a Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vital Reco	യി	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2 only one)	No 1 Ye	s 2 No
Vita hysici	TO B	examiner? 1 ✓ Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatient 3	DOA Other Nursi	ng Home 5 Re	esidence 6 🗸 Other	Scene
on of anding Pluth	ion:	27. Manner of Death 1 V Natural 5 Pending 28a. Date (Month)	of Injury 28b Time of Injury h, Day,Year)	28c. Injury at Work?	28d. Describe how	v injury occurred	
Division of Vital Records, P.O. pital or attending Physician: The law requires that tours after death ereal Director: After this certificate has been signed by filled in by the funeral director, page 2 should be denacting in the funeral director, page 2 should be denacting the formal director, page 2 should be denacting the funeral director, page 2 should be denacting the formal director of the formal di	Certification:	Suicide Could not be	ce of Injury - At home, farm, street, fa	ctory, office building, etc.	28f. Location (Stre or Town, State		ral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		4 Homicide determined (Specify, 29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, death occurred	at the time, date and place, an			ed
To the Ho within 24 } To the Fun completely	Medical	one) 2 Medical Examiner: On the basis and manner:	of examination and/or investigation,	in my opinion, death occurred	at the time, date and	d place, and due to th	e cause(s)
2	2	29b. Signature and title of certifier		29c, License number O.C.M.E.		9d Date signed <i>(Moi</i> July 22, 2008	nth. Day, Year)
O W	1	30. Name and address of person who completed cau	, ,				
	ate	Jack Titus MD. Deputy Chief Medi 31. Date file Manth Day Year 10 A 22. R	cal Examiner 111 Penn S	Street, Baltimore, MD 2	1201		
Regist	trar	31. Date file (Months Day Year) 8 32. R	in 13. Popular				

EDWARD JOHN LEHNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL Center Rosedale If Under 1 Year | If Under 24 Hrs 6. Sex 1**X** M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 3/04/1927 **Funeral** Days Months Hours 212249804 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. In the Plant of Hems 23a or 28e-f show Important: If them 2 is marked other than "ratural" or Items 23a or 28e-f show any Injury or other traumatic event, he "Morinal Examine in all to moffled at Director BALTIMORE ROSEDALE 10f. Zip Code 21237 10e. Street and Number 6530 LANGDALE RAOD Funeral GOWARD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No δ Specify 3 XWidowed 4 ☐ Divorced WW II Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN eHne 17. Father's Name (First, Middle, Last) Be JOHN LEHNER CATHERINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 LARK MEADOW CT BALTIMORE, MD 21236 19a. Informant's Name/Relationship (Type. Print) GARY LEHNER/SON 22 LARK MEADOW CT Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

Physician

The law requires that the death certificate be executed

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

burial-t physician the burial been signed by the should be detached has page certificate or Attending Physician: funeral

Box 68760.

P.0.

Division of Vital Records,

To the Hospital o within 24 hours aff To the Funeral Di completely filled in State Registrar

After

thours after death, uneral Director: A death,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Immediate Cause (Final

1 ☐Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

disease or condition resulting in death)

1. Decedent's Name (First, Middle, Last)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

Luna

Due to (or as + consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

3 🗌 Ectopic pregnancy

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Cancer

5 ☐ Other (specify)

1 Tyes

GARDENS OF FAITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 () () 8

24a. Was an autopsy 2 100 1 □Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

Gusten 9000 FRANKLIN md H Square Balto DR Binh N DRIVE

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

2 ER/Outpatient 3 DOA

28b. Time of Injury

DHMH 17 Rev 1/2001

2. Date of Death Month Day

Year 3 2008

4c. County of Death

Baltimore

9. Birthplace (State or Foreign

MARYLAND

10d. Inside City Limits

3. Time of Death

0345AM

1 ☐ Yes 2 XNo

10g. Citizen of What Country? USA

14. Race - American Indian, Black, White, etc.

Specify: WHITE

16b. Kind of Business/Industry

ELECTRICAL

18. Mother's Name (First, Middle, Maiden Surname)

ZAPF

20c. Location - City or Town, State 7/26/08

BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL

1211 CHESACO AVE BALTIMORE, MD 21237

Approximate Interval Between Onset and Death

23d. Date of delivery

Month Dav Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21237

State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month July 22, **Physician** 6:00 PM M Allan Lock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/30/1939 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 MM 2□ F 68 Director 567-50-6423 CA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expaniment than the mylfind at 1 ☐ Yes 2 No Director MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817-United States 8006 Rising Ridge Rd. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No <u>\$</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Veterinary Medicine al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pathologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental i Fred Lock Mav Lee မ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains once. Katherine K. Lock/Wife 8006 Rising Ridge Rd. Bethesda, MD 20817-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 25 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral & Cremation Services m00382 21. Signature of Funeral Service Licens 933 Gist Ave. Silver Spring, Maryland 20910marin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Hr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit Exam Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate 1 □Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No Hospital: P 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 27. Manor of Death 1 ✓ Natural 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred al or Attending F after death, Director: After Certification Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D66896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD GEORGETOWN RD BETHESDA MD eonard M 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 25

Registrar

State of Maryland / Department of Health and Mental Hygiene 008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 01 9:28 illa 23 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore House 5515 ari tus ted Living N/A f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1☑ M 2□ F 132-12-1970 Director Yrs. 93 MA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It's Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director AZ Pima Green Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2026 W. Via Nueva Leon 85614 by Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Deportment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural". or is any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Building Inspector City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John David Liila 2 Lydia Hohtcri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12059 E. Broadway, Tucson, AZ Ken Fones (grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 28 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Valley Cem. ` 4 ☐ Donation 5 ☐ Other (Specify) Sahuaria, AZ 2008 21. Signature of Funeral 9 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the tisease, or con shock, or heart falure. List only s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Final **Physician** ancer disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Orunary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequent of): ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 TUnknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ninknown ension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | Other 1□Yes 2XNo 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number Name and address of person who completed cac se of death (Item 23a) (Type, Print) Benson 3320 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 5 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

KEVIN 08-05513 UNK UNK

2008 24020

VIN A	NC	KNIGHT				
05513 K UNK		Please Type or Print in Black Indelible Ink. State of Maryland / Department of He			ole. 200	3 2402
		1- For State Certificate of De		Reg. N		
Physici Pdical Exam	an/	1. Decedent's Name (First, Middle,Last) Kevin Emmanuel McKnight, Sr.	2. Dat Mor	e of Death oth Da / 18, 2008	y Year	3. Time of Death 1132 hrs
		4a. Facility Name (if not institution, give street and number) 4b. C	City, Town, or Location of Death	/ 10, 2000	4c. County of Death	
Funeral			altimore City Under 1 Year If Under 24Hrs. 8. De	ate of Birth (N	N / A	place (State or Foreign
Director		219-86-0063 XX _{M 2} F 45 Yrs.			6,1962 Cour	htry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
rland -f show	ctor		Edgewood	Láo		1 Yes 2 X XNo
ith the Maryland 23a or 28a-f show any notified at once.	Direc	10e. Street and Number 1317 Gold Meadow Way Apt. 301	f. Zip Code 21040	10g.	Citizen of What Count USA	ry?
ath with items 2	uneral	1 Never Married 2 X Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? (Specify Y pecify Cuban, Mexican, Puerto Rican,		14. Race - Americ White, etc.	an Indian, Black,
after de al", or	by Fu		s 2XX No specify:		Specify: B1	.ack
2 hours "natur	ted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	Isual Occupation (Give kind of work do of working life. DO NOT use retired)		Sb. Kind of Business/In Pier One	dustry
036 vithin 7, ene. er than	Completed	9th Grade	Supervisor		Imports	
215-0 be filed votal Hygi ked other	Be Co	17. Father's Name (First, Middle, Last) Sidney McKnight, Sr.	18.Mother's Name (First, Lola Johr		den Surname)	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departnet of Health and Mental Higgi ene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be motified at once.	ToE	19a. Informant's Name/Relationship (Type, Print) Glenda McKnight/ Wife 1317 (dress (Street and Number or Rural R Gold Meadow Way	oute Number #30	r, City or Town, State, 1 Edgewoo	zip Code21040 od, MD
s land of Health If item	•	20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	place)		0c. Location - City or T	
timo t. Page rtment c rtant: y or oth		4 Donation 5 Other Specify:			Randallst	
Bal permi Depar Impo injur			e and Address of Facility Chatn O Belair Road E			
Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.				Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):	-			Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
.\.	xamine	cause. Enter Underlying Cause (Disease or injury that initiated		_		
executed and al - transit	ш	events resulting in death) Last Due to (or as a consequence or): d.				
a a	ledic	UNPENDED AMENDED			Date of delivery	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be death earthfrate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burily	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	leath 3 Ectopic pregnancy		23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending	ysic	1 Yes 2 No 9 Unknown 9 Unknown 5 Other	(Specify)	_		9
ires that the signed by the detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I. 2		cco use contribute to t	
ords, F w requires ts been sign should be		ļ -	- 12	4a. Was an	24b. Were aut	opsy findings available
of Vital Records, ng Physician: The law requir After this certificate has been si neral director, page 2 should b	Completed			autopsy performe ✓ Yes 2	ed? death?	ompletion of cause of
Vital R ysician: T his certific director, p	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only or	ne)		
of Viling Physic	ြ	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 7. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Other Nursing Hom y 28c. Injury at Work? 28d. I		sidence 6 Other:	Scene
on o tending eath tor: Afl the fun	ation	1 Natural 5 Pending FOUND: FOUND:		ect shot	r injury cood.	
Division of N To the Hospital or Attending Phy within 24 hours after death To the Funeral Director: After ti completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Yard	0	r Town, State	eet and Number or Rur e) Ave., Baltimore Cit	
Divi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred control of the control of th	at the time, date and place, and due to	the cause(s	s) and manner as state	d.
To th withir To th comp	Medical	Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29b. Synature and title of certifier	in my opinion, death occurred at the ti 29c. License number		d place, and due to the gd. Date signed (Mon	
		(Re-Laleur	O.C.M.E.		July 19, 2008	****
2	ı	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Sti	reet, Baltimore, MD 21201		-	
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature 33. Registrar's Signature				
Regist	rar	JUL 2 2 2000 RAGINGED NO. MARINE				

OCME

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

32. Registrar's Signature

The Contract

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month nn **Physician** laruce 7:10 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 5. Social Security Number 8. Date of Birth (Month, Day, Year) 01/23/1920 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours 88 Yrs. 220-07-9139 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 29a 2 any injury or other traumatic event, the Medical Forms 20 or 20a 2 to 20a. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21220 1317 Sleepy Hollow Lane U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 194
If Yes, Give
Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1942 1 ☐ Never Married 2 Narried 1 ☐ Yes 2 XNo Specify þ Specify: White 1946 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Marucci Carmela Iamonoca 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Sleepy Hollow Lane, Baltimore, Maryland 21220 Mary Frances Marucci (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 07/25/2008 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Fungal Service Livers Part 1 Cobe the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imme te Cause (Final dis se or condition Onset and Death **Physician** POTENSION dis se or condition resulting in death) /Medical Due to (or a onsequence of) Examiner ococcus Sepsis STaphy Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death Last burial-transit Severe attending physician and d for use as the burial-tra Due to (or as a consequence of): resulting in death) Last Box 68760, AORTIC Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) igned by the at be detached f 2 No ☐ Yes P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has perform Yes 2 X No 1 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 🗆 DOA ည this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: hours after death. Ineral Director: After 1 Naturai 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C completely filled To the Hospital 29a. Certifier Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sig ature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 MU 0019340 address of person who completed cause of death (Item 23a) (Type, Print)

441

State Registrar JEFFREY BRINKER

31. Date filed (Month, Play, Yar's 2008)

32. Registrar's Signature

OOO NOITH WORE

600 North Wolfe St, Baltimore, MD, 21287

Amend 24a, per MD G883 9/23/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1010 Tule Year HABEL **Physician** MACK **A** M 23 2008 /Medical 4a. Facility Name (If not institution, give street and number)

North WEST Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Boltimore Randalls town If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Hours Months 212-34-9245 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 Yes 2 No A Funeral Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Numbe 101 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ac \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE College (1-4or 5+) Elementary/Secondary (0-12) Government rica 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mil ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HIN BOITS ·NO Mack HUSBAND 2811 Grenshammy larence 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Rurial 2 □ Cremation 3 ☐ Removal from State Landa 115TOWn 4 □ Donation 5 □ Other (Specify) -30.2008 22. Name and Address of Facility | - well 21. Survice Licensee BERRY 17 46001 21207 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): ay Tract Infection **Examiner** Sequentially list conditions, in any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 → Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1XYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ပ္ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D65843 , 23, 2008 completed cause of death (Item 23a) (Type, Print)

of Frouni 540/ Old Court Road, Rondallstown, MD 21133 MAFROUNI 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar Bellona

			for State	State of Maryland /	Department of H Certificate of L			\sim \sim \sim \sim	24025
			Registrar 1. Decedent's Name (First, Middle, Last	0	dorimodio or E		2. Date of Death		3. Time of Death
	Physici: /Medic		Mancy	Gallowa	y Mana	er	July a	ay acos	11 20A.M
Jan.	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	4	c. County of Death	
W [*]	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last b	70 If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	MORC pplace (State or Foreign
	Director		(A 1) (1) 0 0 0 1.	IM 240 F 89	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	919 BAL	TIMORE, MD
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City. To	wn or Location				10d. Inside City Limits
	Maryl I-f sho	ţ	MD BALTIN		Cockeysvi	110			1 □Yes 2 No
	or 28a	Director	10e. Street and Number	2	10f. Zip Code	116.	10g. C	Citizen of What Cou	untry?
	s 23a	ral	13 Flanders 1	ridge Ct.	210	30		<u>USA</u>	
	ter de	Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene Hygiene than "natural", or items 23a or 28a-f show the than "natural", or items 23a or 28a-f show ant, It a feetlest Evanting rout be multiped at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □Yes 2 No	Specify:		Specify: W/	hite.
<u>5</u>	be filed within 72 ho ttal Hygiene. d other than "natu event, the Modical	Completed	15. Decedent's Edu (Specify only highest grad	cation 16 e completed)	ia. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	lurina most of workin	g 16b.	Kind of Business/li	ndustry
212	withir jiene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Soff Cmok	read		Artist.	
and	~ = 0 %	BeC	17. Father's Name (First, Middle, Last)	9	19.	18 Mother's Name	(First, Middle, Maide	en Surname)	
_	nould be d Menta narked natic ev	ဥ	Jennis C. C	palloway		Nina	H. KC	7	01075
Mary	2 st and is n		19a. Informant's Name/Relationship (7)	rpe. Print)	9b. Mailing Address (Street a	/ F. A	. /// /'	of Town, State, Z	ip Code) 2/030
ē,	es 1 and of Health f Item 27 r other t		20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other place	s Kidge	307	Location City or T	own, State
Ē	Pages ment of ant: If It ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal nom state	-1 D × 1 /2	- 1 - 1 -	5/08 B	ALTIMOR	E MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		22. Name and Addres		DO RD.	BALTIMOR	E, MD 21234.
_	40 2 % O		23a. Part1. Enter the disease, or compl	ications that caused the death De	Evans Func	ral Chap	el + Crema	tion Seen	Approximate
J	Physician	1	shock, or heart failure. List only o	ne cause on each line.	- Overice			and and	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		UXD ZONO.	7	viere	Un- Knoon
	Examiner	_	Sequentially list conditions.	o					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
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09/90	rtificate be executed ng physician and as the burial-transit	edical		i					
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Ž D D	death of atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		1		23d. Date of deli Month	very Day Year
ָ כ	at the o	hysi	9 ☐ Unknown	9 🗆 Unknown					
	res tha		Part II. Other significant conditions co	1 0		A .			the cause of death?
ecords,	been should	eted	Do b	rune,	coronary)	4 Voy			obably 4 Unknown
ě	he law e has l ge 2 s	Completed by	Jemany				24a. Was an autopsy performed?	prior to c	topsy findings available ompletion of cause of
ן נפו י	lan: I rtificat tor, pa	0	25. Was case referred to medical			26. Place of Death	(Check only one)	√o 1 □Yes	2 □No
> :	or Attending Physician: The law requires that the death certifier death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use a	To B	1 163 2120140	lospital: 1 ☐ Inpatient 2 ☐ ER/C		er: 4 🗆 Nursing Hom	ne 5 Residence	6 Other (Spec	in Assisted
	aling F	ion:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b.	Time of 28c, Injury Work'	?	8d. Describe how inj	ury occurred	Living
	Atten r death sctor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,		/es 2□No	8f. Location (Street)	and Number or Ru	ral Route Number,
5	ralor rs afte al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)			City or Town, Sta	ite)	
		Medical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my knowledger. On the basis of examination a	ge, death occurred at the timand/or investigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause and at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	o the vithin 2 or the comple	Med	29b. Signature and title of certifier	and manner stated.	29c. License	number	29d. [Date signed (Month	ı, Day, Year)
	> - 0) ME MD		D-	38754		7-24-	
	18	ļ	30. Name and address of person who compared to the second	empleted cause of death (Item 23a	(Type, Print)	RIVO		2122	
	Stat	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	TE (EXCV)	SUV V	10(.0 -	-12	<u> </u>
	Registra	ar	JUL 2 5 2008	plane to 1	and the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 24026 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MILC 2008 HOMAS UL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner BALTIMORE BALTIMORE CIT GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 17, 1924 Social Security Number 6. Sex 1☐M 2☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 84 Months Freeland, PA Director 202**-**16-0849 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show The marked other than "natural", or Items 23a or 28a-f sh traumatic event, I'm in click in a ruther. 1 ☐ Yes 2 No Maryland Baltimore Co. Director Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21234 United States 3023 Arizona Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2ŽNo Specify. Specify: White If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Bethlehem Steel Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Milcarek Josephine Lynn ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is I any Injury or other trau. Nicholas J. Milcarek (Son) 2713 Youngs Drive Haymarket, VA. 20169 20b. Place of Disposition (Name of cemetery, crematory or other place) EVaris Furieral Chapel 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 20c. Location - City or Town, State Date ly 26, 2008 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Rd. Timonium, MD. 21093 Signature of Funeral Service Licensee 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFARCTION ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury / (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Records, Division of Vital within 24 hours a

To the Funeral C

completely filled

> State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

KERITH

30. Name and address of person who compl T

SEPH

DHMH 17 Rev 1/2001

LOCAL

and manner stated.

M.D.

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

5601

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

att PAL

29c. License number

LEN BUD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death

24027

Physician /Medical
Examiner
Eumonol

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Registrar 1. Decedent's Name (First, Midd	dle, Last)						2. Date of De			3. Time of Death
ın	VERNA L. ORLAN	DO						Month JULY	Day 23,	Year 2008	10:40 A
al er	4a. Facility Name (If not institution	on, give street and	number)		4b. City, To	wn, or Locat	tion of Death		4c. Cot	inty of Deat	h
	CROFTON CONVALES	CENT CENTER	3		CROFT					E ARUND	
	5. Social Security Number 219.20.6005	6. Sex 1 M 2 X		yrs. last birthd 86 Yrs	Months D		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da FEB 4,		9. Birti	hplace (State or Foreig nuntry) PA
	Usual Residence of Decedent 10a. State 10b. Count	ty	10c.	. City, Town o	r Location				 		10d. Inside City Limit
to	MD ANNE	ARUNDEL		CROFTON							1 □Yes 2 N
Director	10e. Street and Number	MONDEL		Onor ron	10f. Zip Co	ode			10g. Citizen	of What Co	puntry?
	2131 DAVIDSONVIL	LE RD.			211	14				US	A
Funeral	11. Marital Status		Decedent Ever i	in U.S.	13. Was Deceden					Race - Ame Black, White	erican Indian, e. etc.
ρ	1 ☐ Never Married 2 ☐ Ma 3√3 Widowed 4 ☐ Divorce	arried 1 TY If Yes ed Year	es 2 No Give XX or Dates:		1□ Yes Ž		ecity:			ecify:	SHITE
etec		ent's Education lest grade complet	ted)	(6	ecedent's Usual C	done during	most of work	ing	16b. Kind	of Business/	/Industry
Completed	Elementary/Secondary (0-12)	Collec	ge (1-4or 5+)		fe. DO NOT use				BOU	nr no	
	17. Father's Name (First, Middle	e (ast)			SECURITY (Jother's Nam	e (First, Middle	-	SE CO.	
o Be							OUISE	,		,	
ှ	PETER KROSHEFS 19a. Informant's Name/Relation		1	19b. M	lailing Address (S			al Route Numb	er, City or To	own, State, 2	Zip Code)
	DARLENE WEBB		DAUGHTEI	R 152	8 WINFIELD	S LN.	GAMBR I LI	S, MD 21	054		
- 5	20a. Method of Disposition		20	0b. Place of D	isposition (Name crematory or othe		į.	Date	20c. Locat	ion - City or	Town, State
	1 XX Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				GE CEMETER		7.28.2	2008	ELKRI	DGE, MD)
	21. Signature of Funeral Service	e Licensee	0		22. Name and A	Address of F	Facility MF P A				
	K. GREGORX FII	NK	M011	48	426 CRAUN	HWY SI	W GLEN E	URNIE, M	D 21061		
	23a. Part1 Enter the Jisea e, shock, or heart failure.	or comulications that only one cause	nat caused the o	death. Do not	enter the mode of	of dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Intervat Between
	1										Intol rat both col.
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	disease or condition resulting in death)	a. Ou	o to (or as a ger			Dries	42				Onset and Death
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DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 July 22, 9:45 A.M Giuseppe Paoli 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4404 Bennion Road Montgomery Wheaton If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 25, 1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Country)
Italy Months Days Hours 1**X** M 2 ☐ F 5**77-**66**-**2560 78 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 4404 Bennion Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emilio Paoli Cornelia Tramontana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elena I. Paoli/Daughter 5006 Keystone Avenue, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. July 23, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 2008 4 Donation 5 DOther (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy 21. Signature o Funeral Service Licensee MO0198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part 1. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? History of Atrial Fibrillation 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 1⊠ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number aluan D20367 July 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850-4302 Kalman, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

DHMH 17 Rev 1/2001

within 2.

Medical

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Bobbye Ruth Peltier 22, July 2008 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15012 Westbury Road Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 410-52-1003 Director Sept. 8, 1932 Tennessee Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Eventine must be an once. 15012 Westbury Road 20853 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2K No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reba Lovina Cross Jacob Amos Wakefield ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15012 Westbury Road, Rockville, Maryland 20853 Irving Peltier / Husband 20b. Place of Disposition (Name of cometery, crematory or other pla Norbeck Memorial Park July 25, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Olney, Maryland 22. Name and Address of Facility Robert A. Pumphrey Fumeral Home/ lockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee ahro Ann Rockville, Inc. 30 Rockville, Maryland ▶ M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Brain Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has tirector, page 2 s autopsy performed? 1 □Yes 2X No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Funer completely fill 29a Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number July 22, 2008 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2008 JUL Registrar

Exam Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be credited at once. Baltimore, Maryland 21215-0036

Physi /Med

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

- State Registrar	Type or Prin AM-ND TII-N State of Ma			tificate of D			eg. No.	20	08	240
1. Decedent's Name (First, Middle, Las	,					Date of Deat Month	Day		Year	3. Time of Dea
	Petersen					Ju1y	23,	200	8	3:25 A
a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or L	ocation of Death			County		
9226 Villa Drive Social Security Number 6.8	7 450	(In our land hin	th do .)	Bethe:	sda If Under 24 Hrs.	8. Date of Birth		ontg		ry place (State or Fo
7hU 3	DM oFF	e (In yrs. last birt. 88	Yrs.	Months Days	Hours Min.	July 7,	Year)	20	Con	intry) t Virgin:
Jsual Residence of Decedent		-	1			July 7,	194	20	WC51	vilgin.
0a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City L
Maryland Montgome	ry			Bethesda	3					1 ☐ Yes 2 ₽
0e. Street and Number				10f. Zip Code		1	0g. Citiz	en of W	hat Cou	intry?
9226 Villa Driv					0817			ited		
1. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	1		e - Amer c, White,	ican Indian, , etc.
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ N If Yes, Give Year or Dates:	10	1	□Yes 2⊠No	Specify:			Specify:	Wh	ite
15. Decedent's Ed	lucation	16a.	Deced	ent's Usual Occupat	ion		16b. Kir	nd of Bus	siness/Ir	ndustry
(Specify only highest gra	de completed) College (1-4or 5-		(Give k	ind of work done du O NOT use retired)	ring most of work	ing				,
Elementary/Secondary (0-12)	Odlege (1-40/5-	· .	Seci	etary			Fede	eral	Gov	vernment
7. Father's Name (First, Middle, Last)				1	8. Mother's Nam	e (First, Middle, I	Maiden S	Surname	9)	
Frederick Willia	am Berens,	Sr.			Elizab	eth Hopp	er			
19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing	Address (Street ar	nd Number or Ru	ral Route Number	r, City or	Town,	State, Zi	ip Code)
John Petersen/Son	n			Shelton	Street,					
0a. Method of Disposition 1 ☐ Burial 2 ဩ Cremation 3 ☐	Removal from State			ition (Name of atory or other place)	July :	25,			,	own, State
4 □ Donation 5 □ Other (Specify		Cremat	mer	im, Inc.	200	-				Maryland
21. Signature of Funeral Service Licen	see		22.	Name and Address	of FacilityRob	ert A. P	սաքի	rey	Fur	neral Hon
dogn Int		M01498	Be	ernesda, M	laryland	20814		, , ,,	TSCC	morn Ave
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each line	the death. Do n e.	not ente	r the mode of dying	, such as cardiac	or respiratory arr	est,			Approximate Interval Betwee Onset and Dea
Immediate Cause (Final disease or condition	a Blade	der Cano	cer							1 year
resulting in death)	Due to (or as a	a consequence o	of):							
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Sequentially list conditions, fany, leading to immediate cause. Enter Underlying cause, pulsease or minny	Due to (or as a	a consequence o	01):							
hat initiated events resulting in death) Last	c Due to (or as a	a consequence of	of):							
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	d									
F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy					,	23d. Date	e of deli	verv
in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)			1	Mor		Day Yea
t ☐ Yes 2 🙀 No 9 ☐ Unknown	9 Unknown									
art II. Other significant conditions o	ontributing to death bu	it not resulting in	the un	derlying cause giver	in Part I.	23e. Did to	bacco u	se contr	ibute to	the cause of deat
Stroke						1 □ Y	es 2 Ş	₹ No	3 ☐ Pro	obably 4 🗍 Unk
						24a. Was a		24b. V	Vere au	topsy findings ava
						autops	med?	d	leath?	
						1 □ Yes	2 🔯 No	1	□Yes	2 □No
					26. Place of Deal	th (Check only or	ie)			
5. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Out	tpatient	Othor				i □Othe	er (Spec	cify)
examiner? 1 ☐ Yes 2 ☑ No 7. Manner of Death	28a. Date of Injur	y 28b. T	tpatient	3 DOA Other	4 ☐ Nursing Heat	th (Check only or ome 5 \to Reside	ence 6			cify)
examiner? 1 □ Yes 2 ☑ No 7. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y 28b. T	lime of	3 DOA Other 28c. Injury Work?	4 ☐ Nursing Heat	ome 5 🙀 Resid	ence 6			cify)
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examiner? 1	28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc	y 28b. T ry - At home, far (Specify)	Time of njury	3 □ DOA Other 28c. Injury Work? 1 □ You occurred at the time estigation, in my op	4 ☐ Nursing Hat at es 2 ☐ No e, date and place inion, death occu	28d. Describe h	ence 6 ow injury treet ann, State cause(s) date and	d Number	ed er or Ru anner as and due	ral Route Number s stated. to the cause(s)
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examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc 28a. Place of Injury building, etc	ry - At home, far (Specify) of my knowledge examination and ted.	rm, stre	DOA Other 28c. Injury Work? 1 1 Y et, factory, office occurred at the timestigation, in my op 29c. License D 2 3 5	4 Nursing Hates 2 No	28f. Location (S City or Town, and due to the corred at the time, of	ence 6 ow injury treet ann, State) cause(s) date and 29d. Dat	d Number and mail place, a e signed	er or Ru anner as and due	s stated. to the cause(s) n, Day, Year)

DHMH 17 Rev 1/2001

Regis

Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exprision or other traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, After s after dea... ral Director: Aff

Director Funeral 9 Completed Be Examine Physician/Medical þ Completed Be Certification: To within 24 hours a To the Funeral C Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Philpot 7:58 AM ಎಂಂಶ lacqueline July **a**a 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Hopkins Bayview Medral Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year 9/1/1924 7. Age (In yrs. last birthday) 6. Sex Days Hours Min. 1 □ M 2 X F 83 212-20-9286 md Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore 1 ☐ Yes 2 X No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 U.S.A. 3446 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Seay Frank C. Kirschner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3446 Liberty Pkwy Baltimore, MD 21222 19a. Informant's Name/Relationship (Type. Print) Frank Philpot/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 7/25/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 8717 Green Pastures Dr. Towson, MD 21286 Signature of Funeral Service Licensee MO1443 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure hours disease or condition resulting in death) Due to (or as a consequence of): fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. that initiated events resulting in death) Last Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

autopsy performed

28d. Describe how injury occurred

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

2 **N**O 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number RES -000 29d. Date signed (Month, Day, Year) 22,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Steinberg 31. Date filed (Month, Day, 5 2008

4940 Eastern Avenuc 32, Registrar's Signature

Baltimore, Maryland 21224

State Registrar

			1 - For State of Maryland / Department of State of Maryland / Department / De	artment of Health and M rtificate of Death		ene 3. No. 2008 2403	2
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Edward Lawrence Palder		Date of Death Month	Day Year 9:20 P M	
	Exami		4a. Facility Name (If not institution, give street and number) 15115 Interlachen Drive, #418	4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
	Funeral Director		5. Social Security Number 578-18-3400 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 85 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, December 5	9. Birthplace (State or Foreign Country) Massachusetts	ın
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show with Injury or other traumatic event, the Medical Examination unit to indifind anone.	ctor	10a. State 10b. County 10c. City, Town or Lo Maryland Montgomery Silver Sp			10d. Inside City Limits 1 □Yes 2X No	
		Funeral Director	100. Street and Number 15115 Interlachen Drive, #418	10f. Zip Code 20906	10g	g. Citizen of What Country? United States	
		Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Nes 2 □ No If Yes, Give 1944— Year or Dates: 1946	Was Decedent of Hispanic Origin? (SprifYes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Caucasian	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4gr 5+) Pharm	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) acist	ing	Sb. Kind of Business/Industry	
yland ;	ould be filed Mental Hyg arked othe artic event,	To Be C	17. Father's Name (First, Middle, Last) Louis Palder	Celia (ur	•		
	l and 2 sho Health and Im 27 Is m		19a. Informant's Name/Relationship (Type. Print) Sharon Palder Rosenblatt -daughter 46.				
Baltimore,	permit. Pages 'Depertment of Himportant: If ite eny Injury or of once.		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	anon Cemetery 7/22	2/2008 A	de Location - City or Town, State delphi, Maryland	
Ba	permit. Depertr Imports eny Inji		21. Signature of Funeral Service Licensee 28	errerson runeral (55 Castlewellan D	Chapel rive Alex	kandria, Va. 22315	
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or complications that caused the death. Do not ent shoo, or heart failure. List only one cause on each line. Immediat 2 cause (Final disease or condition resulting in death) a. Acute Myocardial I Due to (or as a consequence of):	er the mode of dying, such as cardiac o	or respiratory arres	tt, Approximate Interval Between Onset and Death	
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	iner	Sequentially list conditions, if any, heaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	art Disease		15 years	
		dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
		Completed by Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
	w requires that been signed should be det		Part II. Other significant conditions contributing to death but not resulting in the ur Aortic Stenosis	derlying cause given in Part I.		cco use contribute to the cause of death? 2 ☎ No 3 ☐ Probably 4 ☐ Unknown	n
			25. Was case referred to medical			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No	е
f Vi	dir dir	To Be	examiner? 1 Yes X No Hospital: 1 Inpatient 2 ER/Outpatien	011	h <i>(Check only one)</i> me 5 XResidend	ce 6 ☐ Other (Specify)	
on of	d ing Pf h. After tt funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
	Per sat	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	1.2.100	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
	To the Hospital or Atti within 24 hours after de To the Funerel Direct completely filled in by th	Medical	29a. Certifier (Check only one) 1	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cau red at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)	
	To	2	29b. Signature and title of cortifier Wwstrk W	29c. License number D09748		d. Date signed (Month, Day, Year) July 22, 2008	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, I Alan R. Weinstock, MD 10313 Georgia A	venue,#105 Silver	Spring,	Maryland 20902	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		- 0/		
DH	/IH 17 Rev 1/20		JUL 2 5 2008 Sent & Speed	S-J			_

DHMH 17 Rev 1/2001

10a. State

5. Social Security Number

214-34-4052

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

6. Sex

1 🕅 M 2 🗆 F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4c. County of Death Baltimore

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★No

Date of Birth Month, Day, Year) 04/16/1938

Birthplace (State or Foreign Country)
 MD

10d. Inside City Limits

1 □Yes 2 No

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Days

State	e of Maryland / Department of Health and N	Mental Hvaid			
For State Registrar	Certificate of Death	Reg	. No.2 (800	24033
1. Decedent's Name (First, Middle, Last)		2. Date of Death		.,	3. Time of Death
LOUIS	PUCCI	MODILLY	Lay.	20018	12:44AM

Months

Center

7. Age (In vrs. last birthday)

10c. City, Town or Location

70

Funeral

Physician

/Medical

Examiner

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral infractor, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

ţŏ	MD BALTIMORE	В	BALTIMORE					1 □ Yes 2 X N	
Be Completed by Funeral Director	10e. Street and Number		10f. Zip Code			10g.	10g. Citizen of What Co		
	2331 OLD COURT ROAD	, #207		2	21208		USA		
	11. Marital Status 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Fes	Decedent Ever in U. d Forces? es 2 X No , Give or Dates:		as Decedent of H Yes, specify Cub □Yes 2X No	Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 🏋 No Specify:		14. Race - Ame Black, White Specify:		
	15. Decedent's Education (Specify only highest grade comple: Elementary/Secondary (0-12) College	ed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
S	5	ge (1-4or 5+)	JUDGE				AT LAW		
To Be	17. Father's Name (First, Middle, Last) LOUIS		PUCCI WINNIFERD				SEIDMAN		
	19a. Informant's Name/Relationship (Type. Print) BRYNA PUCCI / WIFE		1	,		ural Route Number, C #207, BALT	-		
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal f 4 □ Bonation 5 □ Other (Specify)	om State	20b. Place of Disposition (Name of cemetery, crematory or other place)				BALTIMORE, MD		
	21/ Signature of Funeral Service Licensee	20117				SOL LEVINS ROAD, PIK			
o Be Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,					Approximate Interval Between Onset and Death	
	resulting in death) Du	Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT							
	Cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a conseq							
	in the past 12 months?	, outcome of pregna live birth 2☐ Feta Pregnant at time of d Jnknown	2 Fetal death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac						acco use contribute to the cause of death? s 2√No 3 Probably 4 Unknow		
	CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an autopsy performed prior to death? 1 Yes 2 24b. Were an prior to death?							utopsy findings availal completion of cause of	
	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:								
tion: T	27. Manner of Death 28a. I	Pate of Injury Month, Day, Year)	28b. Time of 28c, Injury at 28d. Describe how injury occurry						
dical Certification: T	3 Suicide 6 Could not be 28e. F	lace of Injury - At he uilding, etc. (Specif	y · At home, farm, street, factory, office (Specify) 28f. Location City or 7				on (Street and Number or Rural Route Number, Town, State)		
dical C	29a. Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On and	the best of my kno he basis of examina manner stated.	wledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	ee, and due to the cau curred at the time, date	se(s) and manner a e and place, and du	as stated. e to the cause(s)	

7601

32. Registrar's Signature

OSLER

ORIGINAL

M.D.

29d. Date signed (Month, Day, Year) 29c. License number 08 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON. MARYLAND

Me

State

Registrar

29b. Signature and title of certifier

BOON FOH LIM.

JUL 2 5 2008

31. Date filed (Month, Day, Year)

08-05575

Elizat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

2008 24034

izabeth M. Quee	1- I	or State Certificate of D	eath			Reg. No.		3. Time of Death	
hysician	<i>I</i> 1.	ilstrar Decedent's Name (First, Middle,Last)			2. Date o Month July 2		Year	1000 hrs	
let Examine	45	Elizabeth Mary Queensbury Facility Name (if not institution, give street and number) 4b.	City, Town, or L	ocation of Dea		40	. County of I	Death	
		1231 West Pratt Street	Baltimore	13011-1041	In In Date	of Birth/MM	N/A	9. Birthplace (State or	
Funeral	5.	Social Security Number 6. Sex	Months Days		lin.	-04-19	- '	Foreign Country) Germany	
Director	12	19-68-1264 1 M 2XXF 51 Yrs.			1 08-	-04-19	301	Land Levi de Cita Limi	
any		aual Residence of Decedent a. State 10b. County 10c. City, Town or Location						10d. Inside City Limi	
*	_ N	aryland N/A Baltimore				10a Ci	tizen of Wha		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Funeral Director	De. Street and Number	10f. Zip Code 21217				ed Sta		
th the l	֓֞֞֞֞֓֞֓֓֞֜֞֞֜֞֓֓֓֞֞֜֞֞֞֞֞֞֞֓֓֞֞֞֞֞֞֞֞֜֞֞֜	721 N. Carey Street Marital Status 12. Was Decedent Ever in U.S. 13. Was 1	Decedent of His	spanic Origin? ((Specify Ye	s or No-	14. Race -	- American Indian, Black,	
ath wi	ner	Never Married 2 Married Armed Forces?	s, specify Cuban	i, Mexican, Pue	erto Rican, e	tc.)	White,		
fter de	~ I	B X Widowed 4 Divorced If Yes, Give Yeer 1 Y	res 2 X No		of work don	a 116h	Specify: T	White siness/Industry	
tours a	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during most during mo	s Usual Occupat st of working life	e. DO NOT use	retired)		. , , , , ,		
36 in 72 h han "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Assistar	nt Manag	ger			etail		
15-0036 Ited within 77 Hygiene. d other than the Medical	ĕ -	7. Father's Name (First, Middle, Last)		18. Mother's N			en Surname))	
215 be file ntal H rked o	a V	Walter Beatty	Address (Stre	Hedwig	or Rural Ro	ute Number,	City or Tow	n, State, Zip Code)	
2 21 should and Me	ို	(Fiance) 1721 F	N. Care	y Stree	t Bal	timore	Mary!	land 21217	
and 2 sealth a tem 27 traum		Luis Arroyo 20b. Place of Disposition	tion (Name of ce	emetery,	Date	20	c. Location -	- City or Town, State	
DOFE ages 1 nt of H t: If i		1 X Burial 2 Cremation 3 Removal from State Arbutus Ce	emetery					s Maryland	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.								Home Of Dund	
Per De lii III		23d. Part I. Enter the disease, or complications that caused the death. Do not enter the	c. 7922	wise A	liac or respir	atory arrest,	shock, or he	eart Approximate Inte	
sician Medical	1	failure List only on cause on each line.	,	10				Death	
Examiner	- }	Immediate Cause (Final disease or condition resulting in death) a. Multiple Sharp Force Injuries Due to (or as a consequence of):							
		Sequentially list conditions, b.							
	Examiner	fr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
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60, ste be e hysicia e buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		. Deu 1-			23d. Date of Month		
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physic ector, page 2 should be detached for use as the bur	sician/N	140	etal death ther (Specify)	3 Ectopic p	oregnancy		Wiena	/	
Sox Jeath c e atten I for us	ysic	1 Yes 2 V No 9 Unknown 9 Unknown				00a Did tob	acco use cor	ntribute to the cause of deat	
O. E at the d by th	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying caus	se given in Parl	11.			3 Probably 4 Unkr	
s, P.O. nires that the signed by d be detact	ed by				— ¦	24a. Was ar		o. Were autopsy findings av	
ords Iw requas been	Completed				-	autopsy perform	red?	death?	
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ician: s certif rector,		25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatier		Other	Nursing Ho	me 5 F		6 🗸 Other: Scene	
of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should l	<u>ا</u>	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pooding FOUND: 1 Natural 5 Pooding FOUND:	, mgany	Injury at Work?	Sut	Describe ho	ow injury occurred stabb	ed	
OD Cending sath. or: All the fur	tion	9 Pending let 21 2008 0950 hrs		✓ Yes 2	No	-		imber or Rural Route Number	
Division tal or Attendii rs after death. al Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	reet, factory, οπι	ce building, etc	123	or Town, St 1 West Pra	ate) att Street, E	Baltimore, MD	
Dospital bours incral		4 W Homicide (Specify) Retail Store							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opi	mon, death oo	curred at the	time, date a			
To Too	Med	29b. Signature and title of certifier	1	cense number			29d. Date s July 22,	signed (Month, Day, Year)	
_		/ (amterely)	°	.C.M.E.			July ZZ,		
1.		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Per	nn Street, B	altimore, M	ID 21201				
Ψ		31 Date filed (Month Day Year) 3 Registrar's Signature							
Regi	State stra	1111 9 5 2008 Placence IF 408	when _						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year $11:35 A^{M}$ Ju₁v 21 2008 Warren Curtis Rose 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Montgomery Hospice Casey House Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F 287-28-5677 76 February 13, 1932 Ohio Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Potomac Marvland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 11010 Rock Run Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Armed Foliass.
1 X2 Yes 2 □ No.
If Yes, Give Korean
Year or Dates: Conflict 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Rose Grace May Burson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynnette E. Rose / Wife 11010 Rock Run Drive Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 28, 2008 Rockville, Maryland Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 W. Montgomery Ave. Rockville, MD 20850-2805 M00896 23a. Part1. Ent if the / sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 AUnknown Esophageal Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation autopsy 1 ☐ Yes 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify)Hospice Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner be executed physician and s the burial-trans Box 68760, attending p P.O. the þ signed b Division or Vital Records, has page 2 certificate this funeral After t Hospital or Attending hours after death. 24 hours after death Funeral Director:

Physician

Funeral

Director

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or Items 23a or 28a-f show Jry or other traumatic event, the Medical Examiner must be notified at

permit. Pages Department of Important: If It any Injury or or

Physician

/Medical

/Medical

To the I within 2

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd., Rockville, MD 20855 Genevieve Anne Wroblewski, M.D.

and manner stated.

31. Date filed (Month, Day, Year) 2 5 2008



DHMH 17 Rev 1/2001

29a. Certifler

(Check only

29b. Signature and title of certifie

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

July 22, 2008

Amend #5, perFH g882 8/22/08 TT

Certificate of Death

Reg. No. 1 - For Asstate Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 19 Day 2008 Year **Physician** 4:10 PM_M David Warren Rabenhorst /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery Derwood If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 02/13/1921 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Country, Days Min. Hours Months 1 M M 2 □ F 87 97-28-5221 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Experience must be notified at Director 1 ☐Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906-United States 3419 Island Creek Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Research and Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mentai Hygiene. Important; If item 27 Is marked other than any Injury or other traumatic event, The M College (1-4or 5+) Engineer Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Rabenhorst Loretta Capell ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Rabenhorst/Wife 3419 Island Creek Ct. Silver Spring, MD 20906-Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Jul 22 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee m00382 22. Name and Address of Facility
Rapp Funeral & Cremation Services Stylle & Thursday that cause 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) EREBRAYECU /Medical Due to (or as a consequence of): Examiner TRACTHE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the detached 9 Unknown 9 Unknown à ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24037 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day 2008 Year 20, 4:35 PM Angel Manuel Rivera 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Harford Upper Chesapeake Hospital Bel Air 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 9/02/1936 Puerto Rico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 581-50-2076
Usual Residence of Decedent 71 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 1313 Goldmeadow Way Apt. 201

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a five dical Experiment to motify of once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Funeral

Director

Physician /Medical **Examiner**

physician and s the burial-transit law requires that the death certificate be execute

signed by the attending p Hospital or Attending Physician: The

Division of Vital Records, P.O. Box 68760

Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

żo	MD	Harford		Edg	gewo	od							1 □Yes 2 → Yo
al Dire	10e. Street and Nur 1313 Go	nber 1dmeadow	Way	Apt. 2	201		ip Code 1040				10g. Citize	en of What Cou	untry?
Be Completed by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Married	· Armed F	2 No Give	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. ■ Yes 2 □ No Specify: Puerto Rican Rican 14. Race - Ameri Black, White, Specify: White							, etc.	
pleted		15. Decedent's Edu	e completed		1 (0	Decedent's Us Give kind of wife. DO NOT	vork done d	urina most	-500	can	16b. Kind	of Business/l	ndustry
E O	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)	Tr	uck D	rive	r			Tra	nspor	tation
To Be C		(First, Middle, Last) Rivera							's Name <i>(Fir</i> noma			urname)	
		lame/Relationship (T) Baulista		ghter	19b. N	Mailing Addre 9 E .	ss (Street a Just:	nd Numbe is Si	r or Rural Ro L Ap Vilin	t. Beton	er City or DE	Town, State, 2	,
		sposition Cremation 3 F 5 Other (Specify)		n State	cemetery,	peake peake	rother place		Date	- 1	20c. Loc	svill	
	21. Signature of Fu	uneral Service Licens	ee M	21413		22. Name 8717		s of Facility	CAFA			D. Loowson	ohrmann P , MD 2128
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										Approximate Interval Between Onset and Death		
Completed by Physician/Medical Examiner	Compostially list conditions												
ysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								2:	3d. Date of del Month	ivery Day Year		
d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use										o the cause of death?		
Completed								_	24a. Was	an	24b. Were au prior to death?	utopsy findings available completion of cause of	
Be (25. Was case referexaminer?						12.		of Death (C	heck only	one)		
ion: To	1 Yes 2 27. Manner of Deat 1 X Natural	th 5 ☐ Pending	28a. Dat	Inpatient 2 te of Injury onth, Day, Year)	28b. Tir	me of ury	28c. Injun Work	4 □ Nu / at ?	28d.		idence 6 how injury	Other (Spe	cify)
27. Manner of Death Natural Suicide Accident Accident Suicide Accident Accident Accident Suicide Accident Acci										ural Route Number,			
edical C	29a. Certifier (Check only one)	ertifying Phy	iner: On the										
Ž	29b. Signature and	title of certifier	lhow	her	17		29c. License	number	40		29d. Date	3-2	th, Day, Year) 1-08
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1308 Busses Let Day #107 Cologensed 7D 21040 31. Date filed (Month, Day, Year) 32. Registrar's Signature												
te 31. Date filed (Month, Day, Year) 32. Registrar's Signature													

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2005 an Month **Physician** 20 Cora Ravnor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE WASHINGTON ITER GLEN BURNIE ANNE MEDICH CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 213-26-7674 April 19, 1929 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, It is Ne item Exa. intermust be notified at once. 1 ☐ Yes 2 ☐ No Director Md. Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3500 Mountain Rd. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. þ White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education ify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Chairs Henry Α. Emma မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 145 Carvel Beach Rd. Baltimore, Md. 21226 Wade E. Raynor (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 7/26/08 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Rome PA 21. Signature of Financial Service Dicenses 3111 Mountain Road Pasadena, Md. 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or cor pil lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25BROYASCI Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician is be detached for use as the burlal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) a Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been stage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this completely filled in by the funeral 28c. Injury at Work? 27. Many fer of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗹 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2. and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIO

State Registrar

31. Date filed (Month, Day 25

MOST

me and address of person who completed cause of death (Item 23a) (Type, Brint)

32. Registrar's Signatur

Word

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend State of Maryland / Department of Health and Mental Hygiene
Per FH g881 730 / 08 TT

Certificate of Death

Reg. No. 200 Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:14PM JAMES SM17H 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HUSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)1920 12/23/1923 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Min. 1**X** M 2□ F 218-01-1209 87 **Director** Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director 1 XYes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 347 Marydell Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼17es 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ White Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event. College (1-4or 5+) Marine Pipefitter Ship repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Hauk Amy Miller မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. Smith/ Son 347 Marydell Road, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Ceme. 7/28/08 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Fireral Home, Inc. 4107 WIlkens Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONZA DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 5BES70525 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed PRUSTATE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 JULY, 23, 2008 Fint) FOHN KUTTARTHZ -STREET, BALTZMURE, MD, 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S0U74 HANOVER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edna Pauline Spring 2008 1:33 P M July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Sept. 26, 1906 West Virginia Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min 230-46-8425 101 Director Usual Residence of Decedent the Maryland 10a. State ral", or Items 23a or 28a-f show Exemple: must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Ifem 27 is marked other than "natural", or Items 23a or ury or other traumatic event, Ife M. Acta Exarcher must be ury or other traumatic event, Ife M. Acta Exarcher must be 303 Adclare Road 20850 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude B. Smalts, Sr. Bessie Fachion Heatwole ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Spring - son PO Box 3375, 313 Curry Ford Ln. Gaithersburg, MD 20885 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or one. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 7-19-08 Mt. Hebron Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Winchester, VA 22. Name and Address of Facility Bobert, A. Pumphrey Funeral Home, Bethesda-Chexy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√☐ Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e Hospital or Attending Phy: 124 hours after death. e Funeral Director: After this letely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2

State Registrar 29b. Signature and title of certifi

Zhang, Wei MD

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901

5 2008

32. Registrar's Signature

Medical Center Dr. Rockville, MD

29c. License number

29d. Date signed (Month, Day, Year)

-15-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** hrei 9 2008 aro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) Stella altimore Maris OSPICE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🛣 F Months 215 40 8685 March 21,1942 Maryland Director ماو Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, it a Medical Examination instruction in the modified at 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director artoro ND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 948 21014 permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if item 27 is marked other than "" any injury or other traumous." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 M2No ò Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) . Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 12 ostal orker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ Lhy dwac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 948 Creek MD 21014 Ochreiber 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 7 - 22 - 2008 Forest Hill, M

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hull MD 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 K No certificate has been signed by the irector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) \(\text{HOSPICE} \) 1∐Yes 2**X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the To the Hosp within 24 hou To the Funer completely fill 29a. Certifier Medical (Check only one) rd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifier 29c. License number

10

8:45

2008

19,

CAROL SCHREIBER

State Registrar DR. ERNESTINE
31. Date filed (Month, Day, Year)

30. Name and address an erson who completed cause of death (Item 23a)

WRIGHT 2300 DULANEY VALLEY RD.

32. Registrar's Signature

Print)

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:00 p.M July 23, 2008 Randy Short /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford 3115 Mahonia Way Edgewood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 XM 2 ☐ F Director 62 Aug. 14, 1945 218-44-1310 Maryland Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2XXNo Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3115 Mahonia Way 21040 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 XYes 2 ☐ No If Yes, Give Year or Dates: Vietnam Specify: White 1 ☐ Yes XXNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Short Shirley Payne 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, Judith Ann Short (Wife) 3115 Mahonia Way Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from_State Oak Lawn Cemetery 4 ☐ Donation ☐ Other (Specify)

21. Sign ure ☐ neral Service Licensee 7/28/2008 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. W 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FFT BRAIN G ue to (or as a consequence of): BRAIN GLIOBLASTOMA **Physician** 7 WEEKS /Medical Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☆ No 24a. Was an certificate has page 2 autopsy performed? 1∐ Yes 2 🔀 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? To the Hospital or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07/24/2008 D 31856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DESH P-SHARMA, MD 602 S. ATWOOD RD #106 BRC AIR, MD 21014 12+1 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

-	For State Registrar	State of Maryland	Cei	tificate of l	Death	R	eg. No. 20 (08 24043	
Physician /Medical	1. Decedent's Name (First, Middle, Las Marie	Joanne	S	chultz		2. Date of Deat Month July 2		Year 8 11:45 M	
Examiner	4a. Facility Name (If not institution, give Genesis Long (•		4b. City, Town, or Bal	Location of Deat		4c. County of	f Death	
Funeral Director	214-38-2806	¬145 – ```	7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day) 8 – 26 – 1	940 M	9. Birthplace (State or Foreign Country) Maryland	
show ed at or	Usual Residence of Decedent 10a. State 10b. County MD		Town or Lo					10d. Inside City Limits 1 ⊠ Yes 2 □ No	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examir or must be notified at once. To Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code 212	24	1	0g. Citizen of Wh	nat Country?	
it er must it er must Funeral	3706 Chestle I	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race	- American Indian, White, etc.	
tural", or	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	1 Tyes 2 TNo If Yes, Give Year or Dates:		1 □ Yes 2 👿 No dent's Usual Occup	Specify:		Specify:	White -	
t, the Model E	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired Disable	during most of wo	rking	Disabl	led	
arked other atic event, To Be C	17. Father's Name (First, Middle, Last) Owen	Henry	Pri	ice	18. Mother's Na Eva	me (First, Middle, i		errick	
27 ls mai r traumai	19a. Informant's Name/Relationship (7 Viola E. Simmor		1	ng Address (Street Woodcr				State, Zip Code) 21234	
nt: If item	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cřer	sition (Name of matory or other place unt Cem				City or Town, State Maryland	
Importar any inju	21. Signature of Funeral Service Licen	<u> </u>	22	Name and Addre	ss of Facility	7	Funeral	l Home MD. 21224	
rsician ledical	23a. Part 1. Enter modis ase, or compshock, or heart fail re. Lift only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. a	Do not ent		ng, such as cardia			Approximate Interval Between Onset and Death	
in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
g physician and as the burial-transit edical Examir	that initiated events '								
etached for use as the etached for use at the etached for use as the etached for use at the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3[☐ Ectopic pregnand ☐ Other (specify)	zy -		23d. Date Mon	e of delivery hth Day Year	
bed bed	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the u	nderlying cause giv	ren in Part I.	23e. Did to	4.0	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	
page 2 should						24a. Was a autop perfor	sy pr med? de	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No	
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatio	ot 2 DOA Oth		eath (Check only of	ne)		
led in by the funeral dir Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Inju Wor M 1	ry at	28d. Describe h	ow injury occurre		
y filled in by		28e. Place of Injury - At he building, etc. (Specifications)	/) wledge, deat	th occurred at the t		City or Tow ce, and due to the	n, State) cause(s) and ma	nner as stated.	
To the Funeral Director: Aft completely filled in by the fun Medical Certification	29h Signature and title of certifier	niner: On the basis of examina and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
- 0	· Bi Co	Willan n	no	7	3/136		JULY 2	24,2008	
9	30. Name and address of person who	completed cause of death (Item ALL ACE MI)	23a) (Type,	Print) S KILE	BRIDE	RD, BA	HITIMO	24, 2008 DRE MD 21231	

State Registrar

Sarkin	R	- For State	faryland / Depa Cer	rtificate o			Reg. 2. Date of Death	No. 2	2008 241 13. Time of Death	141
Physicia lical Exami	an/	Decedent's Name (First, Middle,Last) JOHN SARKIN					2. Date of Death Month Duly 22, 200	Day Year 18		
mei =xeiii		4a. Facility Name (if not institution, give street	t and number)		4b. City, Town, or	r Location of Death	1	4c. County o		7
		8729 Loch Bend Drive #229			Parkville	45.0			Baltimore County	
Funeral Director		5. Social Security Number 6. Sex 1219-56-4275 1XM 2	7. Age (In yrs. I	ast birthday) Yr	If Under 1 Yea Months Day		_		9. Birthplace (State or Fore Country) MARYLAND	eign
	Ŀ	Usual Residence of Decedent		, Town or Loca	ntion				10d. Inside City Limi	its
ow any		10a. State 10b. County N/A			RE CITY				1 X Yes 2	1
daryland 28a-f show 1 at once.	Stor	10e. Street and Number			10f. Zip Code		10g	g. Citizen of Wr	hat Country?	
he Mai or 28, fied at	Director	309 E. MELROSE AVEN	IUE		21212	<u>)</u>		USA		
with t ns 23a ye noti		11. Marital Status 12. V	Was Decedent Ever in U	1.S. 13. W	Vas Decedent of Hi Yes, specify Cuba	Ispanic Origin? (S	Specify Yes or No-		e - American Indian, Black, te, etc.	
death or iten	Funeral	Never Married 2 A Married 1	Armed Forces? Yes 2 X No	1			, 2,		WHITE	
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she ral Examiner must be notified at once	<u>a</u>	3 Widowed 4 Divorced If Yes, or Da 15. Decedent's Education (Specify only high	ates:	16a. Decede	Yes 2 X No	ation (Give kind of			usiness/Industry	\dashv
72 hour	eted		College (1-4 or 5+)	during	most of working life	fe. DO NOT use re	tired)			
Giff " fig	힐	12TH GRADE		PLU	JMBER				EMPLOYED	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygies and anti-filed yillion 27 is marked other than "matural", or other traumatic event, the Medical Examines or other	S	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	aiden Surname	e)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	ELLIS SARKIN 19a. Informant's Name/Relationship (Type, F	Print)	19b. Maili	ing Address (Stre		CKINLEY Rural Route Numb	per, City or Tov	wn, State, Zip Code)	
MD 2 td 2 should tith and M m 27 is m	ပို	WILLIAM SARKIN/BROT					LEN ARM,	MD 21	1057	
e, h I and: Health item 2		20a. Method of Disposition	20b.		osition (Name of co		Date	20c. Location	- City or Town, State	
nor Pages ant of at: If		1 Burial 2 X Cremation 3 Re	emoval from State ME'.			INC. 7/	25/2008	CATONS	SVILLE, MD	
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If fiem 27 is marked other injury or other traumatic event, the M.		21. Signature of Funeral Service Licensee		22	. Name and Addres	ess of Facility TH	E JOHNSO	N FUNER	RAL HOME, P.A.	, 7
		1	7	٤	3521 LOCH	I RAVEN E	RIVD. TO	WSON, M	MD 21286	1
Physician		23a. Part I. Enter the disease, or complicate	ons that caused the deat	h. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre		eart Approximate Inte Between Onset	
Physician 'Medical 'aminer		failure. List only one cause on each fin Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	bns that caused the deather. caine & mor to (or as a consequence to (or as a consequence	th. Do not ente	er the mode of dying	ng, such as cardiac	or respiratory arre		eart Approximate Inte	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 22^{Day} 2008^{Ye ar} 19:36 Barbara Lee Shipley 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carrol1 Westminster Carroll Hospital Center Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) Min. Days Hours 1 □ M 2 🛱 F 9. Yrs. Oct. 219-30-5143 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Carrol1 Marriottsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21104 6903 Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∏ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Care Activities Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis P. (Unknown) C. Jennings Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6903 Ridge Road Marriottsville, MD 21104 Mr. Thomas P. Shipley (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/26/2008 Mays Chapel UMC Cem. Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL,
P.O. Box 195 Sykesville, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examination could be permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tra

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

THOM AS

31. Date filed (Month, Day, Year)

Director

Funeral

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Completed

Be

2

Funeral

Director

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed rsician and burial-trans attending p signed by the a

icate has been signal page 2 should b certificate this certific al director, o the Hospital or Attending Phithin 24 hours after death.
o the Funeral Director; After the ompletely filled in by the funeral within 2

Division of Vital Records, P.O. Box 68760,

Ì	Immediate Cause (Final disease or condition	ISCHEMI	C Bai	sel		Hocky 20 EAN			
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old if medical Exc	resulting in death) Last	Due to (or as a consequ	ncy death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year			
outpicked ay	Part II. Other significant conditions control CINCOLIC COS PRUT CND SMEC ILMO	hive pulmon			./	se contribute to the cause of death? No 3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
2	25. Was case referred to medical examiner?	penital: N			ath (Check only one)				
ALION. 10	1 Yes 2 No 100 27. Mayiner of Death 1 Natural 5 Pending Investigation	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of Injury M	DOA	Home 5 ☐ Residence 28d. Describe how injur				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)			
alcai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
INIC	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 07(12)08								

DHMH 17 Rev 1/2001

State Registrar 291

32. Registrar's Signature

STUNER AVENUE

WESTMINSTER MANUFACTUS?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. GALVIN III MO

08-05546	
Robert Smith	

obert Smith	St 1- For State	ate of Maryland	Department of Certificate of	Health and	Mental Hyg	giene Reg.	No. 2	2008 2404	
Contract of the Contract of th	Registrar 1. Decedent's Name (First, Midd)	le,Last)	Oertinoate of	Dodan		. Date of Death		3. Time of Death	
Physician/ Medical Examiner	Robert Smith			4b. City, Town, or L		Month E July 20, 200	8 4c. County of I	0604 hrs	
	4a. Facility Name (if not institution Maryland General Ho			Baltimore					
Funeral	5. Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		- 1	Birthplace (State or Foreign Country)	
Director	213-62-8091	1 X M 2 F	53 Yrs	3.	D14	Sept. 6	1954	MD.	
aux	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca	tion			10d. Inside City Limits		
<u> </u>	MD			Baltim	ore		1 X Yes 2 No Og. Citizen of What Country?		
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her de	3 Widowed 4 Di	1				Specify:	Black		
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21215-0036 auldibe filed within 7 Mental Hygiene. marked other than ic event, the Medica To Be Comple	17. Father's Name (First, Middle				18.Mother's Name				
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D 21215-C should be filed v and Mental Hygi 7 is marked oth natic event, the To Be CC	19a, Informant's Name/Relation Cheyanne Olive			Arunah Aven					
and 2 sho Health and item 27 is traumati	20a. Method of Disposition		20b. Place of Disp	osition (Name of cer		Date		City or Town, State	
nore ages 1 ant of F nt: If	1 XXBurial 2 Crematic		Mount Zion	Cemetery		25/2008		re, Maryland	
Baltimore, MD 21211 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, To Be	21. Signature of Funeral Service	ce Licensee		Name and Address	•				
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F Vital Physician r this certi	1 Yes 2 No		atient 2 ER/Outpati		Other Nurs	ing Home 5	Residence 6	Other:	
Ing P		28a. Date of I (Month, Da			Yes 2 X No	unk	non injury over		
Sion Attend r death. ector: by the f	2 Accident	vestigation 200 Place of	unk f Injury - At home, farm, s	street, factory, office	building, etc.	28f. Location	(Street and Numi	ber or Rural Route Number, City	
Division of Vital Records, P.C Hospital or Attending Physician: The law requires that bours after death. Funeral Director: After this certificate has been signed tely filled in by the funeral director, page 2 should be deta	Suicide 6 A C	etermined (Specify)	unk			or Town, unk			
e Hosp 124 hou e Fune etely fi									
To the How within 24 h To the Fur completely	and mariner stated.							gned (Month, Day, Year)	
- JOY	29b. Signature and title of certifier 29c. License number O.C.M.E. July 20, 2						800:		
July 1	30. Name and address of person who completed cause of death (Item 23a) Pamela F. Southall, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
7	Pamela E. Southall	, MD Assistant Me	edical Examiner	111 Penn Stre	et, Baltimore,	MD 21201			
Sta Registr	te 31. Date filed (Month, Day, Ye	2008 32. Regis	strar's Signature	W)					
DHMH 17 Rev 1/200			ORIGI	NAL			OCM	E	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SILVERMAN 2008 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Randallstown Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/14/1911 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) ΜD 96 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2X No PIKESVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21208 807 JUDY LANE 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married WHITE 1 □Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

PRINCIPAL

EDUCATION

SNYDER

18. Mother's Name (First, Middle, Maiden Surname)

RACHAEL

807 JUDY LANE, PIKESVILLE, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Wedeal Evandhed must be notified once. Baltimore, Maryland 21215-0036 **Physician**

Physician

/Medical

Examiner

10a. State

MD

Elementary/Secondary (0-12)

NATHAN

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

ZELDA SILVERMAN / WIFE

College (1-4or 5+)

SILVERMAN

Funeral Director

þ

Completed

Be

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Funeral

Director

show

filed within 72 hours after death with the Maryland

/Medical Examiner

law requires that the death certificate be executed

Hospital or Attending Physician: The

within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

burial-tran as for signed t director, page 2 s filled in by the

	20a. Method of Disposition	1	Place of Disposition (Nacemetery, crematory or	me of	Date	20c. Location - City o	r Town, State			
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	BETH TFILO		07/24/2008	BALTIMORE	E, MD			
	21. Signature of Funeral Service Licer	1see Cattle		REISTERS	STOWN ROAD -	NSON & BROS PIKESVILLE				
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dear one cause on each line. a. Due to (or as a conse	Lyocardia	de of dying, such	as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as a consequence of):							
	resulting in death) Last	Due to (or as a consec	quence of):							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic			23d. Date of d Month	delivery Day Year			
d by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Pa		tobacco use contribute]Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4			
Complete					24a. Wa: auto peri 1 □ Yes	opsy prior to formed? prior to death				
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
	1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2	☐ ER/Outpatient 3 ☐ [Other: 4	Nursing Home 5 ☐ Res	sidence 6 ☐Other (Si	pecify)			
ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)								
1										
dical (hysician: To the best of my kn miner: On the basis of examin and manner stated.								
Me	29b. Signature and title of certifier	ouni, HI	2	D658	¥3	July ,22 ,	onth, Day, Year) 2008			
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	but R	oad, Rana	lallstown,	2008 MD 21133			

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUL 2 5 2008

Amend #26 per Verbal G871 7/25/08 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:15 AM **Physician** Charles 2000 Mompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba 8 ICKION 61 W Ka in mor 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 1923 **Funeral** Days Hours Min Months 1 M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at 1 Nes 2 No Completed by Funeral Director MA Timore on L 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 618 2122 CKlow 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race -12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married 1 □Yes 2 ☑No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -it 27 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ompson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 393 BAVENARA, Part 19a. Informant's Name/Relationship (Type. Print) niec permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. MOLL Hntoinette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lifensee 21. Signature Balto 21229 23a. Part 1. riet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Holle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 X I nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably dementia cate has been si page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? hunertansium 24a. Was an autopsy performed hypeatridemia 2. No 1 ☐ Yes 2 No 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 27. Manner of De th Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

Reference of the function of the func 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 060640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVYLE MWINELLUN 710 MWIN 71 Man Prect Relitarium, Mb 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 5 2 Registrar

State

Registra

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. egistrar's Signati 31. Date filed (Mooth Day Year)

111 Penn Street, Baltimore, MD 21201

Colores

2008

08-05593

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24051

	For State egistrar . Decedent's Name (First, Middle, L	ast)	ificate of Death	- 13	2. Date of Dea Month July 21, 2		3. Time of Death ar 2341 hrs
hysician/ 1 xaminer H	arry William Tu	rner, III	4b. City, Town, or	Leasting of D		4c. County	
4	a. Facility Name (if not institution,	give street and number)	Ab. City, Town, or Rockville	Pocation of D	eau	Montgo	
	Shady Grove Hospital	Sex 7. Age (In yrs. las		ar If Under 2	4Hrs. 8. Date of B	irth(MM/DD/YYY	y) 9. Birthplace (State or
uncia	. Social Scounty Hamber	Sex 7. Age (In yrs. last X M 2 F 59	Yrs. Months Day		A.Gor	, 1949	Foreign Country)Maryland
	Jsual Residence of Decedent						10d. Inside City Limit
@ \ '	10a. State 10b. County Maryland Montgo		Town or Location				1 Yes 2 X N
the Maryland tor 28a-f she lifted at once Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	
or 28.	20801 Slidell Ro	ad	20841			United	
	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin	? (Specify Yes or I		ce - American Indian, Black, ite, etc.
or items 23 must be no Funeral	1 Never Married 2 X Marr	ried Armed Forces?			dono i madrij didirij		D1 - a1-
ier de	3 Widowed 4 Divor	ced If Yes, Give Year	1 Yes 2 X N				Black Business/Industry
turs after amine d by	15. Decedent's Education (Specif	y only highest grade completed)	16a. Decedent's Usual Occup during most of working life	ation (Give kir fe. DO NOT us	nd of work done se retired)	16b. Nilid of t	Business/industry
ed within 72 hour lygiene. other than "natu he Medical Exar	Elementary/Secondary (0-12)	College (1-4 or 5+)				Cons	struction
led within 7 Hygiene. I other thau the Medica	12		President/Ow	T19 Mother's	Name (First, Middle		
sygie other of the N	17. Father's Name (First, Middle, L				e Louise		
be fill lirked rent,	Harry W. Turner,		19b. Mailing Address (Str	eet and Numb	er or Rural Route	Number, City or T	own, State, Zip Code)
hould hould is ma rife ev	19a. Informant's Name/Relationsh		20801 Slidel			Marylan	d 20841
d 2 sl lth ar m 27	Lisa M. Turner /	20b.	Place of Disposition (Name of	emetery,	Date	20c. Location	on - City or Town, State
s 1 an if Hea if Tites	1 Burial 2 X Cremation		crematory or other place)		T 1 00 00	OO Batha	ada Maryland
Page nent o ant: or oth	4 Donation 5 Other Spe	ecify: Mon	tgomery Crematorio	m, Inc	July 29, 20	Da Bethe	esda, Maryland
porti	21. Signature of Funeral Service I		Robert A. Pi	imphrey'	Funeral Hon	ne/Bethesda hesda M	a-Chevy Chase, Inc Maryland 20814
P D E III	7.5.1	M0089	6 /55/ WISCO	na. such as ca	ardiac or respiratory	arrest, shock, or	heart Approximate Inte
sician	23a. Part Enter the disease, or a failure. List only one cause	complications that caused the death on each line.	1. Do not enter the mode or dy.	·9, 024			Between Onset a Death
.vledical	Immediate Cause (Final disease	a. Multiple Injuries					
xaminer	or condition resulting in death)	Due to (or as a consequence	of):				
	Sequentially list conditions,	b					
je je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY**Physician** JUDITH E. THOMAS 22. 2008 2:09pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 7682 BRIAR LANE PASADENA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1□M 2□F 241-56-4609 29. 1941 NORTH CAROLINA Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. ?? Is marked other than "natural"; or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County MD ANNE ARUNDEL 1 ☐ Yes 2 TNNo PASADENA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7682 BRIAR LANE 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER DAY CARE SERVICE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be ROGER EDWARDS BETTY AYSCUE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUGH THOMAS husband 7682 BRIAR LANE PASADENA, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY JULY 26,2008 BALTIMORE, MARYLAND 22. Name and Address of Facility MCCULLY POLYNIAK FUNERAL HOME P.A 21. Signature of Fundal Service Licensee MONAZO 3204 MOUNTAIN ROAD PASADENA, MARYLAND 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastic amoullan **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence off Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day for 4□Pregnant at time of death 5 ☐ Other (specify) n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 2 page certificate 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

Sta

31. Date filed (Month, Day, Year)

Dan

30. Name and address of pe

2. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

1650 Orleans St Baltimore, MD 21231

Registra

08-05555		Please Type or Print in Black Indelibl	le ink. Ensure	e All Copies	Are Legib	le.	
Daniel James The			าเ or Health and e of Death	a Mentai Hyg		200	08 2405
Physicia	F	legistrar 1. Decedent's Name (First, Middle,Last)	c or Beari	2.	Reg. N Date of Death		3. Time of Death
Medical Examin		Daniel James Thompson, Jr.			Month Da July 20, 2008		1813 hrs
The same of the sa		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death	
b		8002 Pulaski Highway	Rosedale	Treate 04iles	0. Date of Birth (t	Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	ay) If Under 1 Yea Months Days	s Hours Min.		Foreig	n
Director		220-66-1101 1XM 2 F 40	Yrs.		Sept. 2,	1967	untry) Maryland
япу	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
how r	_	Maryland Baltimore Edgemen	re				1 Yes 2 X No
larylar	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cour	ntry?
the N		7345 Waldman Avenue	21219		U	nited Sta	
death with the N	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	 Was Decedent of His If Yes, specify Cubar 			14. Race - Ameri White, etc.	can Indian, Black,
r deatl	핊	Never Married 2 Married 1 Yes 2 X No	1 Yes 2 X No	annoite:		Specify:Whit	
rs afte		3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupa		rk done 16	b. Kind of Business/	
2 hour	ted		iring most of working life				
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5-0036 led within 7 Hygiene. I other than	S	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, Mai	den Surname)	
121; i be fil ental I arked	8	Daniel J. Thompson, Sr.	Mailing Address (Stre	Agnes Os	inski	r City or Town State	Zin Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	٩		345 Waldman				
, MD and 2 sho ealth and tem 27 is	1	20a. Method of Disposition 20b. Place of	Disposition (Name of ce		Date 2	Oc. Location - City of	Town, State
Ore ges 1 it of H		Burial 2 Xcremation 3 Removal from State	y or other place) p Service C	orn 7/2	6/2008	Towson, M	laryland
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: HIIICOL 21. Signature of Funeral Service Ligensee	22. Name and Address Duda-Ruck				
Ba Perrr Imp		10	Duda-Ruck	Avenue D	ome of L	undaik, I Maryland	nc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying	, such as cardiac or	respiratory arrest	, shock, or heart	Detricen Onder and
Medical aminer	1	Immediate Cause (Final disease a. Oxycodone intoxic	ation & co	caine use			Death
ammer		or condition resulting in death) Due to (or as a consequence of):					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of delive	ery
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Division Hospital or Attend 24 hours after death Finneral Directors tely filled in by the	Cer		hotel room	data and alarm and	Baltimo		tated
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea	ith occurred at the time, nvestigation, in my opini	on, death occurred a	it the time, date a	nd place, and due to	the cause(s)
To the within 7 to the complet	Med	and manner stated. 29b. Signature and title of certifier		nse number		29d. Date signed (A	
	_	11 11 11	0.0	C.M.E. OCA	AE .	July 21, 2008	
Y		30. Name and address of person who completed calls of death (Item 23a)	S				
5 Or pend	10 10	Theodore M. King, Jr., MD. Assistant Medical Exami	iner 111 Penn S	Street, Baltimor	e, MD 21201		
S	tate	31. Date filed (Month), Day Yasr) 2008 32, Registrar's Signature	gane				
Regis	trai						
DHMH 17 Rev 1/2	2001	OR	IGINAL .				

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			Decedent's Name (First, Middle, La	ast)							2. Date of Dea			3. Time of Death
п	Physici		Alfred Paul Ur	ciolo							Month July	21	Year 2008	12:20 P M
	/Medio		4a. Facility Name (If not institution, gir		er)		4b. City,	rown, or	Location of	of Death			nty of Death	12.20 1
1.	Exami	lei	Charlotte Hall		,		Cl	ar1	otte	H211		St	. Mar	v†e
	Funeral				Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8 Date of Birth	1	9. Birth	place (State or Foreign
	Director		577-03-7320	1 ⊠ M 2□F	91	Yrs.	Months	Days	Hours	Min.	May 3,	1917	Wash	ington D.C.
			Usual Residence of Decedent						L				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	show sd at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				'			10d. Inside City Limits
	Man-f sh	ţ	Florida Orang	e	1	Debary								1 Yes 2 □ No
	the 28a	Director	10e. Street and Number				10f. Zip	Code			1 .	10g. Citizen of What Country?		
	3a ol		155 Florence	Avenue			3	3271	3		i	Ur	nited	States
	within 72 hours after death with the Maryland ene. than "natural" or Items 23a or 28a-f show he Medi-al Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.				igin? (Sp	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri	
	r Iter	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Force						n, Puerto	Rican, etc.)	E	Black, White,	etc.
21215-0036	al", o	b	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Date	s:1941 -	1945	1 ☐ Yes 2	X No	Specify:			Spe	ecify: WI	nite
Õ	2 hor	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usua	Occup	ation			16b. Kind o	f Business/Ir	dustry
15	nin 7. n "n Medi	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	or 5+)	(Give life.	kind of wor DO NOT us	e retirea	guring mos f)	t of work	ing			
7	l withii giene. r than the M	티	12	College (1"4	31 34)	Tele	vision	n Te	chnic	ian		Elec	ctroni	cs Company
	be filed within 72 hours after death with the Maryle that Hygher than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho event, the Medi-al Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	t)					18. Mothe	er's Name	e (First, Middle,	Maiden Surr	name)	
Maryland	I 2 should be filed v n and Mental Hygie I Is marked other t raumatic event, th	To B	George Augusti	ne Urciol	.0				Е	the1	Tippet	t		
چ	shound M mar mat	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street			al Route Numbe		wn, State, Zi	o Code)
-	0 =		Glenn Urciolo	/ Son		19220	St.	Joh	nsbur	v La	ne Germa	ntown.	and 20876	
ē,	Hear Hear tem othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	i		Date		on - City or T	
no	ages ant of t: If I		1 the Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Control of the Co		ate	emetery, cre.				11 1 17	25,2008	Pools		Maryland
Baltimore,	artme		21. Signature of Funeral Service Lice		rair									neral Home/
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		18		м00896	_]	Bethes	sda-	Chevy	' Cha	se Inc.	•	•	
			23a. Part1. Enter the disease, or con										Marylan	d 20814-3501 Approximate
			shock, of heaft failure. List only	one cause on each	h line.	II. DO NOCEII	ter the mode	or dyn	ig, sucii as	Cardiac	or respiratory ar	1631,		Interval Between Onset and Death
10	Physician		Immediate Cause (Final disease or condition	_a. AR	RHY	THIN	CA						- 4	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
	Lxammer	L	Sequentially list conditions. b. NYPERTENSION Due to lor as a consequence of:											
7	p #i	ine	Sequentially list conditions, if any, leading to him classic cause. Enter Underlying Cause (Disease or injury	Due to for	as a consel	uence orr								
V	ecute and tran	Examiner	that initiated events resulting in death) Last	C. Due to (or		uses of								
8760,	ate be executed thysician and the burial-transit			Due to (or	as a conseq	derice oi).								
876	ate he be	dical		d										
9	death certifica attending ph	Med	IF FEMALE:					-					107 (20)	
Вох	th ce tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth			∃Ectopic pr	egnancy	,			23d.	Date of delive	very Day Year
-	ed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan 9□Unknow	t at time of c		Other (sp						WOTH	Day Teal
P.0	at the de by the tached	'n	9 ☐ Unknown											
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by F	Part II. Other significant conditions		h but not res	ulting in the u	nderlying ca	ause giv	en in Part I	l.	23e. Did to	obacco use o		the cause of death?
p	en si	ba	DEMEN	11+44							1 🗆 \	Yes 2□N	lo 3∏Pro	bably 4 Unknown
or Vital Records,	s bee	Completed									24a. Was	an 2	4b. Were au	opsy findings available ompletion of cause of
Ä	The lav	E										rmed /	death?	2 □ No
ta			25. Was case referred to medical	T					26 Place	e of Deat	1 Yes h (Check only o	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
>	ysician: is certific director,	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3□DO	A Oth	or /		ome 5 🗆 Resid		î∩ther (Spec	ifu)
0	₹ ∓ @	l⊢.	27. Mannet of Death	28a. Date of	Injury	28b. Time o		8c. Injur Wor		arang ric	28d. Describe			
Division	dlng F h. After funera	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1	Day Year)	Injury	м		k? Yes 2.⊟	No				
S	Attend death ctor: ,	lica	3 Suicide 6 Could not b	28e. Place of	injury - At h	ome, farm, st	reet, factory	, office					umber or Ru	ral Route Number,
Š	lor A after Direction by	i i	4 ☐ Homicide determined	duilding	, etc. (Specia	fy)					City or Tov	vn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the be	est of my kno	wledge, dea	th occurred	at the ti	me, date a	nd place	and due to the	cause(s) and	d manner as	stated.
	e Ho. 24 h e Fur	Medical		miner: On the basi and manner	s of examina									
	o the	Me	29b. Signature and title of gertifier				290	. Licens	e number			29d. Date si	igned (Month	, Day, Year)
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	1400		Will.		of do-th ()	m 02c\ /T:	Drie*\	عا لا	111	00			1-1	3
	130		30. Name and address of person who Leena Rao Kodal:					1.0	D c 1 4	·ima-	. Mass-	land '	21224	
	-01		31. Date filed (Month, Day, Year)		istrar's Signa	100		ьтG	Dall	. ımor	e, mary	rang '	<u> </u>	
	Sta	ite 'ar	1111 2.5	2008	The Standard	S. S. S.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7, 2008 4c. County of Dejath /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Gountry)

Maryland 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 □ M 2 🗗 F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or Items 23a or 28a-f show adioal Examiner must be notified at 1 Yes 2 □ No Director mos 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 ☐ Widowed 4 Divorced Year or Dates: Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) q omemaKe ome or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any injury or other trau-once. 22 20 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 ☐Removal from State 26 12008 4 Donation 5 Dother (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Joseph 2222 23a. Party. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sinon asyl **Physician** Carcinama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Energy of the conditions of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 4 Unknown 1 Tyes 2 🗆 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 27 No Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29d Date signed (Mouth, Day, Year) 29b. Signature son who completed cause of 30. Name and ad death (Item 23a) (Type, Print) SI., Ste soo Baltine, MI) Wolf Jettry

Registrar

State

Date filed (Month, Day;-Year)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Albert Wagner 2008 12:30 PM July 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 7267 Holabird Avenue If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Davs 1**X** M 2 □ F Months 219-38-5778 67 Director January 6,1941 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ∐Yes 2 ∐XNo Director Maryland Baltimore Dundalk 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 7267 Holabird Avenue 21222 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. filed within 72 hours after 1 ∏XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No or, 21215-0036 1 ☐ Yes 2 No Specify ð Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, Its 12 years Carpenter 4 years Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Wagner Violet M. King ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erich Wagner son 53 Dayton Drive, Pasadena, Maryland 21122 July 25, 2008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Crestlawn Cemetery Marriottsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease of complications that caused the shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. onot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Nonsmall cell lung concer **Physician** lanc 400 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the SS attending properties as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) □Yes 2□No ned by the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ t ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a Was an autopsy performed? Yes 2 No certificate 1 □Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home St Residence 6 Other (Specify) 212100 1∐Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uite 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TTFM#19a per INF C882 8/15/08 Tertificate of Death

1- State Amend #11, per Inf G882 8/15/08 Tertificate of Death

Reg. No. 2 Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 22 17 PM 23 2008 Raymond J. Willig 7 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Rosedale Ballimore FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min. 1 XM 2 ☐ F Yrs. Director 71 27, 1936 Maryland 212**-34-**7079 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examinar must be intiffied at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3 Left Aileron Court 21220 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 □Yes 2 ▼No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 7 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Willig Edith Gutridge 19a. Informant's Name/Relationship (Type. Print)

Dorothy L. Willig (Wi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Wife) Middle River, Md. 21220 3 Left Aileron Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopatton 5 ☐ Other (Specify) Heart of Jesus 7/28/2008 Dundalk, Maryland neral Servine License 22. Name and Address of Facility 21. Signature Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner lician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law has be autopsy page performed? certificate 2 No 2 🗆 No 1 □Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MOND

Binh 31. Date filed (Month, Day, Year) State 2008 2 5 Registrar

29b. Signature and title of certifier

H

9000 FR Registrar's Signature

NGUIEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) en

FRANKLIN SQUARE DR BALTO Md

29c. License number

D0065094

29d, Date signed (Month, Day, Year)

7/23/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 24058 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 20, 2008 17:35 P. M Leo Bernard Weber 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Berlin** 4c. County of Death Atlantic General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. January 25, 1939 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months 1 X M 2 F Mary Tand Yrs 212-36-9688 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Ocean City Worcester 10g. Citizen of What Country? 10f. Zip Code 21842 10e. Street and Number 105 Assateague Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Specify: White 1 Never Married 2 MMarried 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Insurance Agent Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Hitchens Leo E. Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State Zip Code)
105 Assateague Court Ocean City Maryland 21842 Loretta M. Weber/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/08 Dundalk Maryland St. Stanislaus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiomyo Parc Due to (or as a consequence of). Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician/Medical

Completed by

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Certification: To

Medical

certificate

the death certificate be executed

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Division

the Hospital or Attending Physicien:

To the Hospital within 24 hours a To the Funeral C

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exameration ust be notified at

and Mental Hygiene.

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any linty or other traumatic event, once.

Maryland

Baltimore,

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		_
 12		

Vear

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No

26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed?∕ 1 □ Yes 2 ☑ No

27. Manner of Death 1 Matural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

1 M Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier David Keeder

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keeder David Market 500

31. Date filed (Month, Day, Year) JUL 2 5 2008 32. Registrar's Signature

12 State Registrar

			For State Registrar	State of Mary	land / Depa			lental Hygi	ene g. No. 2008	24059
	Physic /Medi		1. Decedent's Name (First, Middle, Last Barbara Alsop					2. Date of Death Month July	2 2008	3. Time of Death
	Exami		4a. Facility Name (If not institution, give Anne Arundel Me 5. Social Security Number 6. S	edical Cen	ter yrs. last birthday)	Annap If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Dec 17	4c. County of Death Anne Art	indel place (State or Foreign place) Indies
	Director		Usual Residence of Decedent	□ M 2√ F	69 Yrs.	Months Days	Hours Min.	Dec 17		Od. Inside City Limits
	r 28a-f sho	irector	faryland Anne Anne Anne Anne Anne Anne Anne An	cundel	Crofto			10	g. Citizen of What Cour	1 □ Yes 2X No
	ath with	ral D	1735 Carry Plac	ce		211			USA	
980	ges 1 and 2 should be filled within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be rediffed at	by Fune	Ind. State Ind. State Ind. State Ind. Street and Number Ind. Street and Nu	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □XNo	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, o	etc.
21215-0036	within 72 ho lene. than "natul re Medicel	ompletec	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ng (6b. Kind of Business/Ind Crownsvill State Host	le
Maryland 2	ould be filed Mental Hyg arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Boysie Gibson			77.14	18. Mother's Name	(First, Middle, M	laiden Surname)	71 0 4 3.
e, Mar	and 2 sho fealth and m 27 is me		19a. Informant's Name/Relationship (1888) Beverly Alsop(1888)	Dau Ster)	1735	Carry	Place C	rofton	City or Town, State, Zip, Md. 2111	14
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Metro C	sition (Name of matory or other place remator	y 7-5-	08 1	Baltimore	
Bal	Depar Impor any in		21. Signature of Funeral Service Licen	see ZaeMcOYS	0		*		ery, P.A. , Md. 2140	01
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or empositive shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	lications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac c	or respiratory arre	ist,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burlal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a cor						
Box 687	ath certifi ttending or use as	Physician/Medical	in the past 12 months?	d	Fetal death 3	Ectopic pregnanc	у		23d. Date of delive	ery Day Y ear
P.O.	res that the de signed by the a be detached f	Physi	1 Yes 2 No 9 Unknown	9 Unknown				l oo Billio	4.2.4.2.4.4	
Records,	ne law requires th thas been signe ge 2 should be d	ρ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ui	nderlying cause giv	en in Part I.		acco use contribute to the s 2 No 3 □ Prof	bably 4 Unknown
al Rec	n: The law ficate has b r, page 2 s	Completed						24a. Was ar autopsy perform 1 □ Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
f Vital	ysicial is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatier	ot 3 DOA Oth	er: 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		nce 6 ☐ Other (Specia	6/)
Division of	ine ine	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Injur Worl			w injury occurred	<i>y</i> /
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director. After completely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (S)	pecify)			City or Town		
	To the Hosp within 24 ho To the Fund completely f	Medical	29a. Certifier (Check only one) 29 Medical Examone) 29b. Signature and title of certifier	rsician: To the best of my iner: On the basis of exa and manner stated.	knowledge, death	n occurred at the til vestigation, in my o			ause(s) and manner as a state and place, and due to be a state and place, and due to be a state and place. Od. Date signed (Month,	
	/ 00/ F 3 F 8)	1		Oham Coal C	P56		25	July 2, 2	208
	BA		30. Name and address of person who of			Print) Local Company	ty ANNAS	ous, Md	21401	
	Stat Registra	~	31. Date filed (Month, Day, Year)	8 Hegistrar's S	ignature	and I	,			

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Month

Ju1v

Day

18

Year

2008

United States

Black, White, etc.

Automobile

Manufacturing

Specify:

14. Race - American Indian,

White

21921

21921

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

approx

Year

<u>Cherry Hill, MD</u>

23d. Date of delivery

Month

4c. County of Death

Ceci1

3. Time of Death

0610

10d, Inside City Limits

1 ☐ Yes 2 No

Birthplace (State or Foreign Country)

Virginia

Jackie Bennett Barrett

1. Decedent's Name (First, Middle, Last)

30. Name and address of person who

31. Date filed (Month, Day, Year)

TAYAM

State Registrar 4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

DHMH 17 Rev 1/2001

123 SING

nd cause of death (Item 23a) (Type, Print)

ELMD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2008 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:20PM JULY 2008 EVELYN CECILIA BAXTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** QUEEN ANNE'S 202 COCKEY LANE STEVENSVILLE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Days Hours 1□M 2XF Months Director 214-60-9025 55 MAR.12,1953 MARYLAND Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 ia marked other than "netural", or Items 23e or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 202 COCKEY LANE 21666 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME 8 -0-HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filitiment of Health and Mental Hytant: If item 27 Is marked oth jury or other traumatic eventiury or other traumatic eventi Be KENNARD COUNCILLOR EDNA ROE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES RICHARD BAXTER/HUSBAND 202 COCKEY LANE, STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. STEVENSVILLE CEMETERY JULY 15,2008 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause or each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** yr. 11 mas disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was aп autopsy perform 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 EP/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check_only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature a -14.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8221 TEAL DRIVE, SUITE 302, EASTON, MD 21601 DAVID H. SMITH, M.D., 31. Date filed (Month, Day, Year) egistrar's Signature JUL 14 2008 Registrar

			For State Registrar	State of Maryland	-	irtment of H <i>tificate of l</i>			gienez Reg. No.	000	24062			
				Decedent's Name (First, Middle, Last) Date of De Month										
	Physici /Medio		Ellen Blanche	Brown	July	6, Day	2008	12:45 A.M						
	Examir		4a. Facility Name (If not institution, gir Genesis Health	a street and number)		4b. City, Town, or Annap		eath	4c. County of Death					
			Spa Creek Cent 5. Social Security Number 6.	er Sex 7. Age (In yrs. Ia	Hrs. 8. Date of Birt		Aruno							
П	Funeral Director			1□ M 2X F 85	Hrs. 8. Date of Birt (Month, Da 05/10/	1923	Keer	9. Birthplace (State or Foreign Country) Keene, Va.						
	pug 🗼		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Lo	cation					10d. Inside City Limits			
	Maryla a-faho	tor	D.C.		1 ☐ Yes 2 № No									
	with the	Funeral Director	10e. Street and Number	NI II		10f. Zip Code	20010		10g. Citize	n of What Co				
	eath	erai	241 56th Street	12. Was Decedent Ever in U.S	12 1		20019	2 (Specify Yes or No	. 14	U.S.A				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-1 ahow any injury or other traumatic avant. The Medical Examinat rout be notified at Once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑No If Yes, Give 1			? (Specify Yes or No Juerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black				
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gi	f working	16b. Kind	of Business/	ss/Industry							
21	ed wil	Con	12th	College (1-4or 5+)	Sear	stress			Cleaners					
and	ld be fill ental H ked oth ic avan	To Be	17. Father's Name (First, Middle, Las Patrick Gray	")				Name (First, Middle, her Ross	Maiden Si	umame)				
Maryland	id 2 shou Ith and M 27 is mar traumat)-	19a. Informant's Name/Relationship Doris A. Donatie			mber, City or Town, State, Zip Code) ington, D.C. 20019								
ē,	s 1 an f Hea item 2		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	eal	Date	20c. Loca	ation - City or	Town, State			
Ë	Page nent o int: if		1 X Burial 2 ☐ Cremation 3 ('4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from State	ntico	Nat'1. C	em. 0	7/15/08	Triar	riangle, Virginia				
Baltimore,	permit. Departmit. Imports any inju		21. Signature of Funeral Service Lice	ngton & Sc	Sons Co., Inc. L., Washington, D.C. 20019									
	15		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician		Immediate Cause (Final disease or condition a Cerchy Varcher Occhin											
	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classase or injury that initiated events	b. Due to (or as a consequent	ence of):		-							
,00	ficate be executed g physician and is the burial-transit	i Examiner	Due to (or as a consequence of):											
68760,	cate b	edicai		d										
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes No 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							ivery Day Year			
٦.	res that t igned by be detac		Part II. Other significant conditions	23e. Did 1	obacco us	co use contribute to the cause of death?								
rds	equires en sign ould be	ed by	Dichter U.	- incy tectivi	Lester			10	Yes 2	es 2 0 3 Probably 4 Unknown				
ecords,	aw requir is been si 2 should	Completed						24a. Was	24a. Was an 24b. Were autopsy					
Ä		E O									completion of cause of			
Vital	Physician: this certific ral director.	Be (25. Was case referred to medical examiner?		Death (Check only	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 (Check only one)								
of \	hysi this c	ို	1 Yes 2 Mo	Hospital: 1 Inpatient 2 E			4 Nursi	ing Home 5 ☐ Resi			cify)			
	Jing After fune	ation:	27. Manner of Death Samuel Samuel Pending 2 Accident investigation	(Month, Day Year)	28a. Date of Injury 28b. Time of 28c. Injury at Work? M Yes 2 No					28d. Describe how injury occurred				
Division	To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28f. Location (City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in 1	edical (29a. Certifier Check only one) Certifying P Certifying P Certifying P	hysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, deatl ion and/or in	n occurred at the tirvestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) a date and p	ind manner as place, and due	s stated. e to the cause(s)			
29b. Signature and title of certifier									- 6	signed (Moni				
)	(K)		1 / 1 / 1	Smus		7)	3203	(71	8/201	3			
	Cige		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	Mir	e Chi.h	, M	W 1/	419			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure									

			1 - For State Registrar	ate of Marylar	nd / Depa <i>Cei</i>	artment of H	lealth and N Death	ental Hyg	iene 200	8 24063		
E	22	×	Decedent's Name (First, Middle, Last)	·				2. Date of Deat	h	3. Time of Death		
	Physicia /Medic		Reginald J. Ball				July	2° 2008	1:44 A M			
	Examin	er	4a. Facility Name (If not institution, give street	,			Location of Death		4c. County of Death			
		V	Laurel Regional H	rin	. last birthday)	Laure	If Under 24 Hrs.	8. Date of Birth	9 B	George's		
	Funeral Director		217-16-5619 121		85 Yrs.	Months Days	Hours Min.	OCT ZZ	^Y ef 922 Ma	ryland		
	land ow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
	Mary a-f sh	١٥	Maryland Anne Arun	del 0d	denton					1 □Yes 2X No		
	th the or 28; e not	Directo	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What (Country?		
30	ath w		665 Old Waugh Cha	14		211			USA			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 3 ☐ Married 1	/as Decedent Ever in Urmed Forces? ☑Yes 2☐No Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □ Yes 🏋 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Black, Wh	14. Race - American Indian, Black, White, etc. Specify: Black			
2-003p	72 hou natura lical E									nd of Business/Industry		
Ž	d be filed within 7 ntal Hygiene. ed other than "r event, the Med	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)	ilite. L	DO NOT use retired	,					
7	Hygie ther th	Ö	17. Father's Name (First, Middle, Last)	0	G	eneral :	Services 18. Mother's Nam		NSA Maiden Surname)	·		
and	ld be lental ked o fc eve	To Be	Louis Ball					Washin	· ·	ŕ		
Mary	shou and N s mar		19a. Informant's Name/Relationship (Type. P	rint)	19b. Mailir	ng Address (Street			City or Town, State	, Zip Code)		
a, E	and 2 ealth n 27 i		Mamie A. Ball(Wif				- A.			Md. 21113		
	ges 1 If itel or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove	/al from State	cemetery, crer	sition (Name of natory or other plac	ce)		20c. Location - City			
Daltimor	nit. Partmer		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Mē	J-	d Vetera Muana Ragasa			crownsvi ary, P.A	11e, Md.		
D D	permi Depar Impor any Ir		Janu & Beese Me	c483	- 1				, Md. 21			
			23a ant1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line.									
	Physician		Immediate Cause (Final	Pneumonia		****				Onset and Death		
r :	/Medical Examiner			Due to (or as a conse						-		
	19 mg	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Respirato Due to (or as a conse	quence of):	sufficie		weeks				
	ecuted and -transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to far as a sense.								
0/00,	cate be executed physician and the burial-transit	dical E		Due to (or as a consec	quence on.							
0	rtificate ng phy as the	0	U									
O. DOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of o Month	lelivery Day Year							
٠, ۲	s that ned by e deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Accident Renal Cell Cancer 24a. Was an autopsy performed? 1 Yes 2 No 1									
colus,	equire sen sig ould b	ted b										
ב מ	The law I ate has be page 2 sh	Somple										
V II a	ician: certific ector,	Be	25. Was case referred to medical examiner?	ol.		Oth		ath (Check only one)				
5	Phys r this ral dir	은	I les ZI No	a. 1 ☐ Inpatient 2X a. Date of Injury	ER/Outpatien		4 Nursing Home 5 Hesidence 6 Hother (Specify)					
	ath. rr: Afte	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Injur Wor M 1 🗆	k? Yes 2 □ No		e now injury occurred			
2	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of injury - At r building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (St City or Town	(Street and Number or Rural Route Number, Fown, State)			
Hoenital,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	vithin To th	Me	29b. Signature and title of certifier	alon /	5	29c. Licens	e number 53411	2	9d. Date signed (Mo			
	X	P	30. Name and address of person who comple	ted cause of death /Ito	m 23a) (Type		0) 111		*F	_		
4	J 1000		J. Shesadri, MD		, , , ,) Borric	MA 2	7715			
	Sta		31. Date filed (Month, Day, Year) JUL 0 9 2008	4300 Gal 32 Registrar's Sign	ature	and s	, b∪%1€,	<u> </u>	J / 1. 3			
	Registr	ar	JUL 0 9 5000	Marie .	~ /7							

DHMH 17 Rev 1/2001

amend line 20a per folloase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 07/09/08 dlState of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** UL MARIE /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 29 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Puerto Rico **Funeral** 1 □ M 2√2 F 1926 82 Yrs 220-30-1987 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrorn injury or other traumatic event, the Medical Event. 10d. Inside City Limits 10c, City, Town or Location 10a State 10h Counts 1 ☐ Yes 2 💢 No Director Baltimore Maryland None 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21231 1905 East Pratt St. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1√∑ Yes 2 □ No Specify: Puerto Rican Specify: White 2 3√ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None Housewife 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Esquilin Felix Ayala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3310 Ave H Apt 3D Brooklyn, NY Luz Milagros Ayala(Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Donal 2 Cremation 3 Removal from State Florencion Cemetery 7-12-08 Sajardo, PR 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Miname Alexander Sons Mortuary, P.A. 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death HYPERCARBIC RESPIRATORY Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner HRONIC OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that the death certificate be executed physician and that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 🗌 No Yes certificate 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Inpatient 1 Tes P eral Director: After this filled in by the funeral d 27. Manner of Death Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury or Attending М 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) after To the raw within 24 hours the Funeral Di 1 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier reelyn Wilky, MD JULY 8, 2008 RES-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Baltimore, MD, 21287 A. Wilke Bredyn 31. Date filed (Month, Day, Year) Registrar 0 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

24065

			1 - For State Registrar	0.0.0 0	y tarrar s	Cer	tificate of	Death		F	Reg. No.	_ 0 0 0		000		
100	Physic	3n	1. Decedent's Name (First, Middle, La	•					2	Date of Dea	ith Day	Year	3. Time o	of Death		
	/Medi		Martin K. Bennett						July	05,	2008	7:16	P M			
1	Examir	er	4a. Facility Name (If not institution, give		4b. City, Town, o		f Death			4c. County of Death						
	77		Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth									Anne Arundel				
	Funeral Director		120-01-1824 1XM 2 F 90 Yrs. Months Days Hours						Min.	Month, Day Aug. 0	irthplace (State Country) IEW York					
036	land		Usual Residence of Decedent 10a. State 10b. County		0c. City, Tow	n or Lo	cation						10d. Inside C	City Limits		
	e Mary	ctor	MD Anne Ar	undel	Annap	ροli	İs						1 ☐ Yes	2 XNo		
	th with th	al Director	10e. Street and Number 1650 Trawler Lat	ne			10f. Zip Code 21401				_	zen of What (What Country?			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f show any njury or other traumatic event, Ira Medical Exactinal must be notified at Angles.	by Funeral	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify:					14. Race - American Indian, Black, White, etc. Specify: White				
2	72 ho	eted	15. Decedent's E (Specify only highest gr.	ducation ade completed)	ion 16a. Deced		edent's Usual Occupation				16b. Kind of Busines					
121	within ene. then *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			re kind of work done during most of wo DO NOT use retired) DEMIST					. Food inistr	and Dration	ug		
g 2	filed Hygid Other		17. Father's Name (First, Middle, Last					18. Mothe	r's Name (First, Middle,						
lan	Mental Mental arked o	To Be	Harry Katz			Fran	ncis	ilab								
Mary	nd 2 should lith and Meni		19a. Informant's Name/Relationship (Steven H. Bennet			_			Route Number, City or Town, State, Zip Code) apolis, MD 21401							
Baltimore, Maryland 21215-0036	Pages 1 ar		20a. Method of Disposition 1 🛣 Burial 2 🗀 Cremation 3 🗀 4 🗆 Donation 5 🗀 Other (Specia	Removal from State	Hillcr	ry cren est	sition (Name of matory or other place Memoria	Ge)]	July (200)8,		cation - City o	or Town, State			
	permit. I Departm Importar any nju		21. Signature of Funeral Service Lice		Garden	Ba	emetery Name and Addre Arranco & OS Gov. R	Sons	P.A	. Seve:	rna	- Park F	uneral	Home		
1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final													
14	Physician /Medical		disease or condition resulting in death)	a. Septi	consequence	0 C	Λ					·	2 d q	IXS		
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	ted sit		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):									, .			
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68760	ficate physi s the t	Medicai		_ d.		-										
C. Box	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at time 9 Unknown							23d. Date of delivery Month Day Year					
ds, P.	w requires that the de been signed by the should be detached	þ	Part II. Dther significant conditions of		23e. Did to	death?										
Hecord	e la has	Completed		perfor	utopsy prior to completion of death?			s available cause of								
Vital	iclan: Th certificate rector, pag	0	25. Was case referred to medical					26 Place	of Death (2 No	1 L Y	es 2 No			
	5 S D	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 VInpatient	2 ER/Ou	itpatien	it 3 DOA Oth			ath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)						
ion or	ing After		27. Manner of Death 1 Natural 2 Natural 2 Natural 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury M 1 Yes 2 No 28d. Describe how injury M 1 Yes 2 No 28d. Describe how injury M 1 Yes 2 No 28d. Describe how injury M 1 Yes 2 No 28d. Describe how injury M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? M 1 Yes 2 No 28d. Describe how injury Mork? Mork.									Describe how injury occurred				
DIVISION	al or Attending F s after death. Il Director: After i id in by the funera	Certification:										and Number or Rural Route Number, ate)				
E HOODING	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	edical C	29a. Certifier (Check orny one) Certifying Pt 2 Medical Example (Check orny one)	ysician: To the best of niner: On the basis of example and manner stated	amination an	e, death	n occurred at the tirvestigation, in my o	me, date an opinion, deat	d place, an th occurred	d due to the o	cause(s) date and	and manner place, and d	as stated. ue to the cause	(S)		
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		-	30. Name and address of person who	completed cause of deat	h (Item/2)	(Type	Defen	002	.17	//	0	106	1 20	US		
	to		Paul B. Berez	MD 2	225	E	Defen	58	Hw	V, CI	of	ton	MD 2	1114		
A CONTRACTOR	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 9 200	8 Registrar's	Signature	de	100					/				

State of Maryland / Department of Health and Mental Hygiene 2008 24066 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Bert B. Brooks July 3, 10:15 A. M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 🕅 M 2 □ F 229-34-3517 Director **Unknown** Unknown Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the "Modical Examiner in ast be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Chevy Chase 1√2 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Avenue 20815 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2 | No
If Yes, Give
Year or Dates: Unknown 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer 4 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1900 M Street N.W. Suite 700
Washington, D.C. 20036 19a. Informant's Name/Relationship (Type. Print) Stephen W. Nealon/Nominated Executor 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ceo. Wash. University

Medical Center

2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 XDonation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? ð Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Division of Vital 2 No 2 Î**y**Hio 1 ☐ Yes 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely fi Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20057124 Boo, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 11 Registrar JUL

2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 24067 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Madeline Mary Cutlip $\mathbf{a}^{\,\text{M}}$ July 9, 2008 5:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 434 Bethel Street Wicomico Salisbury 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2**X** F 75 Director 218-28-8809 3/1/1933 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at Director 1 Ves 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 434 Bethel Street 21804 USA death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ,o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. ğ white Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 cashier H & R Block 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Milton Ferguson Rose Mary Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau once. Mary Lou Lee/step-sister 434 Bethel St., Salisbury, MD 21804 20a. Method of Disposition Pages 1 ment of I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/08 Salisbury Crematory: 7/10/08 | Salisbury, MD

22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licenses 501 Snow Hill Rd., Salisbury, MD 21804 CFSP domoson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician noemania disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be execute and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 - Ectopic pregnancy þ in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 1 ☐Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the? 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M9 D0060959 9/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31575 Winterplace Parkway, Salisbury, MD 21804 Ronald Passeri 32. Resstrar's Signature State 31. Date filed (Month, Day, Year, 2008 JUL I Registrar

Physician /Medical Examine death certificate be executed

P.0.

Division or Vital Records.

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the Hospitai

Medical

State

Registrar

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

'natural'', or items 23a or 28a-f show dic∍l Examiner must be notified at

I Hygiene.

d 2 should be filed with and Mental Hygies 7 is marked other tl

Pages 1 and 2 sl ment of Health an ant: If item 27 is r

permit. Page Department of Important: If any injury or once.

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Director

Funeral

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Completed

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attending physician and for use as the burial-transit Physician/Medical ed by the a Completed s certificate has b director, page 2 s funeral director, Be မှ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

> 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

4 Homicide

29a. Certifier

29d. Date signed (Month, Day, Year)

I for cece No

MA

DO4823

Elicton Md 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OHIH HOW MD

31. Date filed (Month, Day, Year)

JUL 1 4 2008

West mai st, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** MARY LOUISE COYLE JULY 11, 2008 01:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE CENTER OF QUEEN ANNE'S CENTREVILLE OUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗰 Director 128-24-7523 76 4/13/1932 NY Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD QUEEN ANNE'S CENTREVILLE 1 ☐ Yes 2 ☐XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mertal Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 2 in yor ofther traumafic event, the Medical Examiner must be n 185 SYMPHONY WAY 21617 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY TELEPHONE COMPANY - 0 -17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES VANDECAR MARY ALICE HOPKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES P. COYLE/HUSBAND 185 SYMPHONY WAY CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation Department of Important: If any Injury or once. 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) CROWNSVILLE VETERANS 7/15/2008 CROWNSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 S. LIBERTY ST, CENTREVILLE, MD 21617 21. Signature of Eunera Secoce Licenses 23a Part1 Frie e, or complicati List only one c ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart Immediate Cause (Final disease or condition resulting in death) Physician - 5 years CHRONIC OBSTRUCTIVE PULMONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical use as t attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.O. signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ ONGESTIVE HEART 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Completed DEMENTA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? yes 2 No certificate 1□ Yes Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of att 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death. To the Funeral Director: After the funeral birds of the birds of the funeral birds of the funeral birds of the b 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1.7 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation in my satisfied the control of the cause of the control of the cause of the c 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 31. Date filed (Month, Day, Year) JUL 14

110

29b. Signature and title of certifie

Helen

egistrar's Signature

and manner stated

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Chestarroun Md 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Month Joanna Herlihy Curtin 3:07 p July 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3160 Gracefield Road, #3125 Prince George's Silver Spring Year of Under 24 Hrs. If Under 1 Yea Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 😾 F Director 579-10-6186 29, 1918 Washington, DC Usual Residence of Decedent Figure 1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination in the braining at once once in the provided at once once in the provided at once once in the provided at once in the pro 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 🕱 No Directo Silver Spring 10f. Zip Code Maryland Prince George's 10g. Citizen of What Country? Funeral 3160 Gracefield Road, #3125 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2¥∑No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Financial Manager 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Jeremiah Herlihy ဥ Sarah J. Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Curtin/Nephew 3804 Ft. Worth Avenue, Alexandria, VA 22304 Date Date 20c. Location - City of Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery July 12 4 Donation 5 Dother (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sepsis days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 ☐ Other (specify) signed by the a I be detached f 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia has been signed 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【素Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No s certificate ha irector, page 2 2 □ No 1 □ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

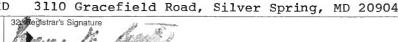
The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, p within 24 hours a ē

Baltimore, Maryland 21215-0036

State Registrar

Eugenio Machado, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D24035

29d. Date signed (Month, Day, Year)

July 10, 2008

			For State Registrar	State of	Maryland /	_		t of He		d Ment		ene g. No. 2	008	240	170	
Jan.	100		Decedent's Name (First, Middle, Language)	2. Date of D												
1	Physici /Medic		Stewart William Diffenderfer							l N	Month Day Year 07/19/2008					
evi	Examir		4a. Facility Name (If not institution, gi		Town, or I	ocation of De	eath		4c. Cour	ity of Death		P ^M				
	16 ME			ospice Found				47/	Easto		(8)			Talbot		
b	Funeral		5. Social Security Number 6.	Sex 7 1	. Age (In yrs. last	birthday) Yrs.	If Under Months		Hours M	lin. 8. D	ate of Birth Month, Day,		9. Birthi	olace (State or I ntry)	-oreign	
	Director		Usual Residence of Decedent		91	110.					9/26	/1916		Pennsylva	nia	
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City	Limits	
	Mary Fied	tor	Marvland	Talbot					Trappe	e		1 □ Yes				
	or 28s	Director	10e. Street and Number				10f. Zip	Code			10	10g. Citizen of What Country?				
	23a c		29160 Krismo				21673			USA						
	r dea	Funeral	11. Marital Status	12. Was Deced Armed Ford	es?	13.	Was Dece If Yes, spe	dent of His cify Cubar	panic Origin? n, Mexican, Pu	(Specify) Lerto Ricar	res or No- n, etc.)		ace - Americ lack, White,			
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	•		1 ☐ Yes	2 No	Specify:			Specify: W				
2-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ed be	15. Decedent's E			l 6a. Dece	dent's Usu	al Occupa	tion		1	6b. Kind of	Business/In			
5	in 72 n "na n Aedic	Completed	(Specify only highest grade completed) (Gi					ork done du se retired)	uring most of v	working						
212	yiene r thai	E	Elementary/Secondary (0-12) College (1-4or 5+)					Mair	itenance				В	akery		
פ	othe othe	Bec	17. Father's Name (First, Middle, Las	it)					18. Mother's N	Name (Firs	st, Middle, M	aiden Surr	ame)			
<u>Ja</u>	should be tand Mental s marked or tumatic eve	To E	N	lorman A. Di					_			da Tho				
an J	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
۶, ≤	and lealth m 27 her tr		Dorothy Ann Tr	umbull/Daug		of Disse	nikian /Ala		8210 Ingl	leton Ci Date			21601 n - City or T	own State		
more, Maryland 2121	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show yr other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		ate 20b. Place	etery, crei	matory or	other place)	Date		OC. LOCAIIO	n - Oily or i	OWII, State		
턡	t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Spec		Mid			tion Cer	nter :	7/21/2	2008		Cambr	idge, MD		
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensee Xan	2//12//	2					222 11	1 D. 1	C 1	.: MD	21612	
	eser in our		23a. P rt1. Enter the disease, or con	molical ons that car	used the death. D								, Camb	ridge, MD Approximate		
			shock, or heart better. List only one cause on each line. Onset and Death											eath		
)	Physician /Medical		disease or condition resulting in death)	a. Due to (o	r as a consequence	ce of):	ANI	7	TELL	urs	_			WEEKE		
	Examiner			1/4	Ival a		4.	N	dis	-ac	4			Xt. Res	,	
	Heat and	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (u	as a consequent		1/	1	1.		1 -	1		1000		
	cuted id ransit	Examiner	Cause (Disease or injury that initiated events	Lyse	rfourne	سملے ر	Mero	50/TT	-ofte	card	10 VAS	cula		Year	<u>~_</u>	
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequent	ce of):					d	15-cm	5-0	L		
8760	cate be executed oblysician and the burial-transit	dical		d						_						
9 ×	eath certific attending pl for use as t	Physician/Me	IF FEMALE:	23c If yes outer	ome of pregnancy	,						004	Date of deliv			
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	in the past 12 months?									Month	,	ear	
o.	the de	ysic	1 U Yes 2 No 9 Unknown 9 Unknown													
J.	The law requires that the death the has been signed by the atter age 2 should be detached for u		Part II. Other significant conditions contributing to death by that resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?					
Vital Records,	quires n sigr ald be	d by	ati	111	Fibri	<u>//</u> ~	KIN	1		_ 4	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briki					
ပ္ပ	aw require s been sig	Completed									24a. Was an autopsy findings prior to completion of ca					
ž	The la	E O									autops perform 1∐ Yes 2	ned?	death?	2 □ No	use or	
<u>m</u>		Be C	25. Was case referred to medical						26. Place of I		100	was a second			-	
	5 in p	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 In	patient 2 ER/	Outpatier	nt 3□D	OA Othe	r: 4 🗆 Nursin	ng Home	5 ☐ Reside	nce 6	Other (Spec	ify)	2757	
n or	ding Pt After th funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of (Month	Injury 28 Day Year)	b. Time o	of	28c. Injury Work	at ?	28d.	Describe ho	w injury oc	curred			
<u> </u>	Attendil death. ctor: A y the fu	catic	2 ☐ Accident investigation				М		res 2 □ No			ation (Street and Number or Rural Route Number,				
DIVISION	or Attenation of Attenation of Director; in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. L	ocation (Str City or Town	eet and Nu , State)	imber of Hu	rai Houte Numi	oer,		
	pltal ours a eral [29a. Certifier 1 Certifying F	Physician: To the b	est of my knowled	dne deat	h occurred	1 at the tim	ne date and n	lace, and	due to the ca	use(s) and	manner as	stated.		
	To the Hospital or, within 24 hours after To the Funeral Dire completely filled in the Funeral Direction of the Funeral D	edical	(Check only one)	aminer: On the bas	sis of examination	and/or ir	vestigatio	n, in my op	oinion, death o	occurred a	t the time, da	ate and pla	ce, and due	to the cause(s))	
	To the To the Comple	Me	29b. Signature and title of certifier	10	147			c. License			29	29d. Date signed (Month, Day, Year)				
)	->-0		> 2+d/2	1 4	MI		1	752	750			7/2	1/0:	8		
			30. Name and address of person who	o completed cause	of death (Item 23	a) (Type,	Print)					-	1			
	<u> </u>		Robert B. Sanchez, M.D.				21601									
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature		1									
	Registr	15	H H T Y K 71111X	STEWN		30/478										

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 7, Day 008 **Physician** Dorothy 9:15 Zapolski DelFuoco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** East Gate Drive, Apt. 304 Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 208-14-1236 Director 3/8/1921 Pennsylvania Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ardrenen of Heath and Mental Hygene. ortant: If iten 27 is marked other than "natural", or items 23a or 28a-f show Injury or other tran mate and the profiled at high or or profiled at the p 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 East Gate Drive, Apt. 304 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 X Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) material planner Watkins and Johnson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph I. Zapolski Mary Walczak ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude D. Smith/daughter 4 Fosse Grange, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/9/08 Salisbury, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Compoor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Murcardia disease or condition resulting in death) /Medical Due to ras a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-transit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after dea.
-ral Director: After
- by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number
D28798 29d. Date signed (Month, Day, Year) 29b. Signature and title of celltifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 314 Franklin the Ste 104. Berlin, MD 21811 31. Date filed (Month State Registrar

08-05244	
Margie Day	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Dea	th	Reg. No.	2008	
Physician/ edical Examine	Decedent's Name (First, Middle,Last)	beth Day		Date of Death Month Day July 8, 2008	Voor	me of Death 115 hrs
	4a. Facility Name (if not institution, give street an Penninsula Regional Medical Cer		Town, or Location of Death	w	County of Death	
Funeral Director	5. Social Security Number 6. Sex 247–44–2582 1 M 2 ^X	Mon	der 1 Year If Under 24Hrs. ths Days Hours Min.	8. Date of Birth(MM/D 08/16/19	Foreign	ce (State or h Carolina
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				. Inside City Limits
Maryland 28a-f show d at once	Maryland Wicomico 10e. Street and Number	Salisbury 10f.2	lip Code	10g. Citiz	en of What Country?	Yes 2 XNo
th the Maryland 23a or 28a-f sho notified at once	505 Woodcrest Ave.		21804		JSA 14. Race - American	Indian Black
or items 23	1 Never Married 2 Married Arm	ed Forces? (es 2 X No	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto R	ican, etc.)	White, etc.	morari, black,
y affe	3 X Widowed 4 Divorced If Yes, Gi or Dates: 15. Decedent's Education (Specify only highes	t grade completed) 16a. Decedent's Usu	No specify: al Occupation (Give kind of wo vorking life. DO NOT use retire	rk done 16b. K	Specify: wh ind of Business/Indus	ite
5-0036 style within 72 hours lygiene. other than "natu	Elementary/Secondary (0-12) Colle	ege (1-4 or 5+) housewi	fe		domestic	
ID 21215-0036 Ib 21215-0036 Is should be filed within 72 and Mental Hygiene. 77 is marked other than natic event, the Medical To Be Comple		11		First, Middle, Maiden	Surname)	
D 2121! should be fill and Mental H is marked atic event, t		19b. Mailing Addre	ess (Street and Number or Ruiverbank Rd.,	ıral Route Number, Ci	ty or Town, State, Zip	Code)
md 2 salth em 2 raum	20a. Method of Disposition 1 X Burial 2 Cremation 3 Remo	20b. Place of Disposition (N	lame of cemetery,	Date 20c. I	ocation - City or Tow	
Baltimore, permit, Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Park	nd Address of Facility Oway Funeral H		alisbury, ssional As	·
m ឱ្យដី ឆ្នាំ Physician	23a. Part I. Enter the disease, or complications	CESO 501 :	Snow Hill Rd.,	Salisbury	7, MD 2180	4 Approximate Interval Between Onset and
'Medical caminer		e Blunt Force Injuries				Death
a di	Sequentially list conditions, b.	or as a consequence of):				
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or as a consequence of):				
ian and ial - tra		DED				
Box 68760, death certificate be the attending physic of for use as the bur	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death 5 Other (\$			d. Date of delivery Month Day	Year
that the death ned by the att detached for by Dhysi	1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributions	Unknown uting to death but not resulting in the underly	ring cause given in Part I.		use contribute to the	
S, P.O puires that the signed by Id be detac				1 Yes 2	No 3 Probab	ly 4 Unknown
tal Records, crian: The law requires certificate has been signer, page 2 should be Completed.				autopsy performed?	death?	pletion of cause of
Vital Rec ysician: The l his certificate director, page	25. Was case referred to medical examiner?	1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check of DOA Other Nursin		ence 6 Other:	
n of ling Ph After t funeral	27 Manner of Death 28a	Date of Injury (Month, Day, Year) 28b. Time of Injury 1000 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how in Driver auto auto	jury occurred collision	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (S	e. Place of Injury - At home, farm, street, fac pecify) Major Road / Highway		28f. Location (Street or Town, State) Tilgman Road and		
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier	he best of my knowledge, death occurred a basis of examination and/or investigation, in	t the time, date and place, and n my opinion, death occurred a	due to the cause(s) a t the time, date and p	nd manner as stated lace, and due to the	cause(s)
To with To com	and ma 29b. Signature and title of certifier	inper stated.	29c. License number O.C.M.E.	29d	Date signed (Month	
regul	30. Name and address of person who can piet		nn Street, Baltimore, M			
Stat	2000	ant Medical Examiner 111 Per 32. Responses Signature		D 2 1201	31	

/Medical Examiner requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, ed by the sign be To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: Af completely filled in by the fun

f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last	c
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) Month Day Year 9 □ Unknown
Part II. Other significant condition Algher Dys Up 1	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home AResidence 6 Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
27. Manner of Death Natural 5 Pending	
29a. Certifier Certifying	Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. kaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar foodman

enverille

32. Regetrar's Signature

Valene C

30. Name and address of person

31. Date filed (Month, Day, Year)

H0057821 29d. Date sig Through the Maryland

29d. Date signed (Month, Dav. Year)

2008

21617

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Ruth Virginia Davidson July 9 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 W F Director 234-30-8922 85 June 12, 1923 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Exercited at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9401 Crosby Road 20910 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Experiment ance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Specify þ 3₺Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thurmond Morrison Lucy Ann Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Highland Drive, Silver Spring, MD 20910
of Disposition (Name of Date 20c. Location - City or Town, State Jill Martinez/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3x Removal from State July 14 Bridgeport Cemetery 4 Donation 5 Dother (Specify) 2008 Bridgeport, WV 21. Signature of Funeral Service Licen-22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring. MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications, or heart failure. List only on lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Immediate Cause (Final **Physician** Minutes disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of). Examiner 3 days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy In the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t autopsy performed? certificate I Certification: To this

Box 68760, P.O. Division of Vital Records,

or Attending Physician: funeral director, death. s after death.

I Director: A in by the fu

To the Hospital within 24 hours a To the Funeral I Hospital

		1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Cther: 4 ☐ Nursing Home	e 5 Residence 6 Other (Specify)
27. Manner of Death ★★Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work? n M 1 □ Yes 2 □ No	ld. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined		if. Location (Street and Number or Rural Route Number, City or Town, State)
One Contilion 455 Contitute Di	hard from To the best of my frequence death accurred at the time data and the	-d due to the course(s) and manner on stated

29b. Signature and title of certifier

(Check only one)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, MD 20850 Wei Zhang, MD

State Registrar

31. Date filed (Month, Day, Year) JUL 11 2008



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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21. Suprogram Funeral Service Licensee 22. Name and Addiges of Facility Agriculture Agricultu		1 🗆 Burial 2	Cremation		from State				; Ju	lv 10.		-	
23e Part Enter the disease, or complications that caused the death. D. not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Consett interval Between Consett and Death (Interval Between Consett and Death Consett and Death (Interval Between Consett		21. Signature of F	ureral Service	Licensee	16		Ba 49	Name and Address Arranco & OS Gov. R	Sons, I	A. Seve	erna :	Park Fu Park. M	neral Home 0 21146
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FFEMALE: 236. Was decedent pregnant in the past 12 months?		Sequentially list of	onditions,		us to for de	B OUT BEGUN	eriou ofly:						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		cause. Enter Und Cause (Disease of that initiated even	lerlying or injury ts		`	·	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** 6:05 PM Edelstein 2008 anne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 1200 Tanley Rd Silver Spring 8. Date of Birth (Month, Day, Year, April 3, 19 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Funeral Hours Days 1 □ M 2 □ X F 1934 Director 089-28-4943 Usual Residence of Decedent 74 10c. City, Town or Location 10d. inside City Limits 10a. State 10h County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Silver Spring Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20906 3603 Glen Eagles Drive #3B Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify. 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Sand and Gravel Co. Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Roth Bertram Schwaab 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1200 Tanley Rd., Silver Spring, MD 20904 Howard Edelstein/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2008 Judean Mem. Gardens Olney, MD Signature of Funeral Service Licensee Hebrew Numeral ngton, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Ovarian Cancer Physician 18 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 21X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2√□ No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) residence Hospital: P 1 ☐ Yes 27 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 8, 2008 D33224 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Rd., Suite # 435, Silver Spring, MD 20910 Trehan M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 1 2008

12. Was Decedent Ever in U.S.

Armed Force 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

College (1-4or 5+) Š+Ì

Anne	Arundel
te of Birth o <i>nth, Day, Year)</i>	Birthplace (State or Foreign Country)
y 21, 1915	Canada

4c. County of Death

10d. Inside City Limits 1 X Yes 2 ☐ No

1:00 A M

10g. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

> White Specify: 16b. Kind of Business/Industry

(Give kind of work done during most of working life. DO NOT use retired) Mount Vernon Public Schoo1

18. Mother's Name (First, Middle, Maiden Surname) Jennifer Eisenstein

2. Date of Death

8,

2008

Month

Ju₁y

8. Da

Ju1

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Peggy Eckhauser/Daughter-in-law 1230 Algonquin Road, Crownsville, Maryland 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

Alexandria, VA

Metropolitan Crematory 7/9/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

10f. Zip Code

1 ☐ Yes 2 🗓 No

16a. Decedent's Usual Occupation

Teacher

21146

Specify:

Physician /Medical Examiner

Examine

Physician/Medical

þ

e squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition

resulting in death)

10e. Street and Number

11. Marital Status

Funeral

þ

Completed

715 Benfield Road

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 XCremation 3 ☐ Removal from State

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Louis Cottler

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Due to (or as a consequence of): nummary

3 months

Year

4 Unknown

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

2 No 3 Probably

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9∏Unknown

24a. Was an 1∐ Yes

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREDERIC EEXITAUSER 1230 ALGUNQUIN RD CRUWSVILLE

31. Date filed (Month, Day, Year)

0 9 2008

Registrar

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed attending physician and for use as the burial-trar ed by the detached To the Hospital or Attending Physician; director,

after death filled in by the

within 24

Completed Be Certification: To

Medical

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

Hospital:

28b. Time of

26. Place of Death (Check only one)

Ass istycl

6. Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 06:25 AM Sam W. Fowler July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Itospiral Agnes None St If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11-30-1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**⊠**M 2□F Washington DC 73 578 44 8994 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 No Directo MD Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 21075 5741 Main St. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Sam W. Fowler Josephine Harris ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5741 Main St. Elkridge, MD 21075 Harriet J. Fowler/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 7-15-2008 Suitland, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 en 6 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Failuse 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner calcinoma Heparocellulas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ abete 1 | Yes 2 | No 3 | Probably 4 | Donknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 212 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

Registrar

29b. Signature and title of certifier

odely

St Agnes Hospital BODDU 31. Date filed (Month, Day, Year) 32. Registrar's Signature 14 2008 JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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29d. Date signed (Month, Day, Year)

900s Caton Avenue, Baltimore

11

Name Kincum to Physician: Gaskewicz, Anthony

Funeral

Director

28a-f show

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}	he N 28a-	Director	Maryland	Cecil		No	rth Eas			
	vith t	급	10e. Street and Nur				10f.	Zip Code		
	ath v s 23a sust	ā	20 Cher	ry Street				21901		
960	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deparmt of Health and Mental Hyglene. Imporant: If item 27 is marked other than "natural", or items 23a or 28a-f should inly injury or other traumatic event, Its Modical Evaminer must be notified at once.	by Funeral	11. Marital Status 1 □ Never Marri 3XXWidowed	ed 2□ Married 4□ Divorced	12. Was Decedent I Armed Forces? 1 Xyes 2 N If Yes, Give Year or Dates 9	10		****	anic Origin? (S Mexican, Puert <i>Specify:</i>	Specify Yes or No- to Rican, etc.)
- 10	2 ho	ted	(0	15. Decedent's Edu	cation	16a	. Decedent's U	sual Occupation	n	
Raltimore Maryland 21215 0026	2 should be filed within 7 and Mental Hygiene. is marked other than "r aumatic event, in Med	Completed	Elementary/Seco	rify only highest grad ndary (0-12)	College (1-4or 5		ife. DO NOT		ing most of wor	rking
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200	y cand be Mental arked catic ev	To Be	Ignaci	ous Gaske	wicz			1	Kathran	ne Zwolal
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07.0	Pages 1 nent of H, ant: If iter ury or oth			☐Cremation 3 ☐ F		cemete	f Disposition (A ry, crematory o	r other place)	June	-
-	permit Page Deparment Imporant: If any Injury o			5 ☐ Other (Specify) neral Service Licens	2	Delawa Memori	al Ceme	rans tery and Address o	200	
ď	permit Departi Importa any in		Illand	14-14	17.				CI	ouch Fur
			23a Part 1 Enter ti	ne disease, or compl	ication that caused	the death Do				et, Nort
			shock, or hea	rt failure. List only or	ne cause on each lir	ine death. Do	not enter the in	200		
	Physician /Medical		disease or condition resulting in death)	n a	LOCON	ryr	11teri	1015	sease	
	Examiner		, receiving in acaim,	•	Due to (or as	a considence	of):			
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œ E	ifficat g phy as the	ğ								
ital Records P.O. Box 68760	death cerl	Physician/Medical	IF FEMALE; 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		c pregnancy (specify)		
C	the o	ıysi	9 ☐ Unknown	INO	9 Unknown					
Δ.	that ned b	P	Part II. Other signif	icant conditions cor	ntributing to death bu	ıt not resulting i	n the underlying	g cause given i	n Part I.	23e. Did to
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9	w rec	lete	5.	•						24a. Was
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}	nysic nis ce direc	9	examiner? 1 Yes 2 □	No F	lospital:	nt 2 ER/O	utpatient 3 🗆	DOA Other:	4 ☐ Nursing H	Home 5 ☐ Resid
ouo	ding Ph h. After th funeral	tion: T	27. Manner of Death	5 Pending Investigation	28a. Date of Injur (Month, Day	v 28b.	Time of njury M	28c. Injury at Work?		28d. Describe h
Division of	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc.	iry - At home, fa :. (Specify)				28f. Location (8 City or Tox
	e Hospit 24 hour 9 Funera etely fille	Medical C	29a. Certifier (Check only one)	1 Certifying Phys		examination ar				
	To the vithin To the complex	Me	29b. Signature and	itle of certifier			2	29c. License nu	ımber	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 3 0 2008

State of Maryland / Department of Health and Mental Hygiene 24080 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May Anthony P. Gaskewicz 2008 /Medical 4a. Facility Name (If not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Dec. 5, 9. Birthplace (State or Foreign Country)
Delaware If Under 1 Year 7. Age (In yrs. last birthday, Sex ¥AAM 2□ F Days 221-18-4242 82 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Ceci1 North East 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20 Cherry Street 21901 United States 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, White Specify: 16b. Kind of Business/Industry Manufacturing Maiden Surname) er, City or Town, State, Zip Code) 21901 , Maryland 20c. Location - City or Town, State Bear, Delaware neral Home th East, Maryland 21901 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an sy rmed? 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2XNo 6 Non-F (SWeetify) Post 6027 now injury occurred Street and Number or Rural Route Number, wn, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

64 IVA

Manyland Health Care System,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amends items 10a-f, 19b per inf 8882 8-15-08 Treb
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar	Cei	rtificate of Death	Reg. N	· 2000 21.001
	Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
· · · · · · · · · · · · · · · · · · ·	/Medi		Theodore Isa				2008 2:50 A M
	Exami	ner	4a. Facility Name (If not institution, give street and Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		c. County of Death Montgomery
	Funeral Director		5. Social Security Number 216-30-2552 Usual Residence of Decedent	F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year June 5, 19	9. Birthplace (State or Foreign Country) Washington, DC
	/land low		10a. State Florida 10b. County Palm Be	ach 10c. City, Town or Lo	Delray	Pooch	10d. Inside City Limits
	a-f sh	ctor	Maryland Montgomery	Silver		Deach	1 □ Yes 2√□ No
	or 28	Director	10e. Street and Number 15630 Loch		10f. Zip Code 2006 33440	_	Citizen of What Country?
	s 23a		15101 Interlachen Driv	Æ #3TO_	20300	OIII	ited States
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dies! Examilizer must be recitied at	by Funeral	Arme 1 Never Married 2 Married 1 Yes	es 2X∏No ,Give	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 🛣No <i>Sp</i> ec <i>ify:</i>	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9	2 hour	ted t	15, Decedent's Education	or Dates:	dent's Usual Occupation	16b.	Kind of Business/Industry
21215-0036	within ene. than "	Completed	(Specify only highest grade complete	(Give ge (1-4or 5+)	kind of work done during most of worki DO NOT use retired) I NESS OWNEY	who	olesale Maintenance
pu	e filed val Hygie	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	1 0
yla	ould b Ment arkec	2	Harry Grossman			e Lieb	
Maryland	12 shuth and 7 is m		19a. Informant's Name/Relationship (Type. Print) Iris Grossman, Wife	19b. Mailir	ng Address (Street and Number or Rum	al Route Number, City	or Town, State, Zip Code)
	s 1 an f Heal frem 2 other		20a. Method of Disposition	15630	Loch Maree Lane, sition (Name of matory or other place)	Unit 6701 Date 20c.	Delray Beach, F1.334 Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe may injury or other traumatic event, once.		1 X Burial 2 □ Cremation 3 □ Removal for 4 □ Donation 5 □ Other (Specify)	Cernetery, crer.	norial Gardens 07/		Iney, MD
3alt	permit. Departi Importa any inji		21. Signature of Free Processing Service Lie ensee		Name and Address Pleasility W	uneral Hom	ne
	20 = a 0		220 Port 1 Files the disease or a will entire at	> 2	54 Carroll St., NW	l, Washingt	ton, DC 20012
	Dharisia	g. 11.	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	to (or as a consequence of):	CELL LYN	16 CAN	CER 34RS
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x 68	ertifica ing ph e as th	Medical	IF FEMALE:				
P.O. Boy	0 2 0	by Physician/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	s that gned b e deta	y Pr	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
org	w require been sig should b	ted t	DIABETES	,		1 ☐ Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	e la has	Completed	VASCULAR	DISEASE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
Vita	nysician: Th nis certificate director, pag	Be (25. Was case referred to medical examiner?	,	26. Place of Death	1	
of	Phys rthis ral dir	Ë.		Impatient 2 ER/Outpatier ate of Injury 28b. Time of		me 5 Residence	6 Other (Specify)
ion	Attending Ph er death. ector: After th by the funeral.	ation	1 Natural 5 Pending (I	Month, Day, Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	zod. Describe flow inj	ury occurred
Divis	al or Attenos s after death I Director: d in by the	Certification: To	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm, struilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, death ne basis of examination and/or in nanner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
_	To the within complete complet	M	29b. Signature and title of certifier	1	29c. License number		Pate signed (Month, Day, Year)
	10		in M/k	mellon	D 35996	July	y 10, 2008
	V-		30. Name and address of person who completed clinda Burrell, M.D., 2	730 University	Print) Blvd., #400, Silve	er Spring,	MD 20902
	Sta Registr		31. Date filed (Month, Day, Year) 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Registrar's Signature	ule		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#29dperMD, 7/11/08, BMW, Mertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 07, рΜ 2008 11:25 Robert H. Ju₁v Grimes /Medical 4c. County of Death a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Montgomery Gaithersburg 8. Date of Birth (Month, Day, Year)
Feb. 27, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1**X** M 2□ F Months Days Hours 579-20-4788 Feb. Maryland 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f sho event, the Medical Evanting must be notified at Director 1 ∏Yes 2 TNo Maryland Frederick New Market 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Box 261 21774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩∏ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married and Mental Hygiene. Is marked other than "natural", or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ğ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institute of Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. Grimes Minnie ဂ္ Mae Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Box 261, New Market, MD 21774 Sharon Imes / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/11/2008 Rockville, MD Parklawn Mem. Park 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Servicensee 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final **Physician** dementi 225 disease or con ***
resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 4 ☐ Pregnant 9 ☐ Unknown ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an cate has by page 2 s autopsy performed? Yes 2 No certificate 1 🗆 Yes Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ה 24 hou. the Funeral Directory filled in by th 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teven 0/103/2-U350 . Registrar's Signature 31. Date filed (Month, Day, Year) State 11 2008 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2/10 PM JUL 2008 CHRISTOPHER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) APRIL 3 /9 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 □ F Days Months 578-13-9184 D.C. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County ns 23a or 28a-f show 1 ☐ Yes 2 X No Maryland Anne Arundel Gambrills Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21054 2647 Carver Rd. Funeral ages 1 and 2 should be filed within 72 hours after deat in to f health and Mental Hygelne.

E. If Item 27 is marked other than "natural" or items 5 for other traumatic event, the Medical Expr. That The Other traumatic event, the Medical Expr. The Other traumatic event, the Medical Expr. The Other traumatic event, the Other traumatic event is the Other traumatic event in the Other traumati Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2**√**∑No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School 12th 0 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joe L. Gipson Cynthia Belt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is □ 2647 Carver Rd. Gambrills, Md. 21054 Cynthia Gipson (Mother) Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition 2011 Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If i any injury or Church Cemetery 7-12-08 Odenton, Md. 4 ☐ Donation 5 ☐ Other (Specify) En ame Percent of circons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 42 AR MOOG 5 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CEREBRAL HERNIATION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INTRACEREBRALAND INTRAVENTRICULAR HENCKRHASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed MOYA MOYA and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE: nse s yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 □ Yes 2 □ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1∐ Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No in 24 hours after death.

Reference of Funeral Director: A letely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4,2008 RE(-000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN BALTIMORE, MD 21224 RYAN LI

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

JUL 0 9 2008

08-05219	
Taylor Goetzke	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aylor Goetzke		5 tate of Maryland /		nt of Health ar te of Death	na Mental H		g. No. 20(18 2408
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Deat Month		3. Time of Death
Medical Exam	iner	Taylor Adam Goetzke 4a. Facility Name (if not institution, give street and number)		4b. City Town o	or Location of Deati	. July 7, 200	4c. County of Deat	0642 hrs
		958 Highpoint Drive		Annapolis			Anne Arunde	
Funeral Director	4	213-37-4262 _{1XXM 2} F 16	(In yrs. last birtho	Months Da		_	h(MM/DD/YYYY) 9. Bi 0,1992 Forei	rthplace (State or gn puntry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County 1	I0c. City, Town o	Location	_			10d. Inside City Limits
Maryland 28a-f show any'	or	Maryland Annapolis		Annapolis				1 Yes 2 No
ith the Maryland 23a or 28a-f sho rrotified at once.	Director	10e. Street and Number 1124 Mermaid Drive		10f. Zip Code 2140	9		Og. Citizen of What Co. United Stat	,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygierd eather and Mental Hygierd other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral I	11. Marital Status 12. Was Decedent E 17 Never Married 2 Married Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cubi		specify Yes or No-		rican Indian, Black,
ter deat ", or it		1 Yes 2	XXNo	1 Yes 2vy N			Specify:	√hite
nours a	ed by	15. Decedent's Education (Specify only highest grade comp	di	ecedent's Usual Occup			16b. Kind of Business	/Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	+)	Studen		,	Learnin	lg l
21215-0036 hould be filed within 72 Mental Hygiene. is marked other than tite event, the Medical		17. Father's Name (First, Middle, Last)	1				Maiden Surname)	
2121 uld be f Mental markee	To Be	Matthew P. Goetzke, Sr. 19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Str		A. McMi.	llian nber, City or Town, Sta	te, Zip Code)
imore, MD 2 Pages 1 and 2 shoument of Health and 1 tant: If item 27 is no or other traumatic		Matthew P. Goetzke, Sr. /Fa	ather 1	124 Mermaio	d Drive	Annapol:	is, Marylan	nd 21409
2 - 2 - 2 - 1		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from Star	te cremator	Disposition (Name of c y or other place)		Date	20c. Location - City of	
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Lakemo					lle,Maryland
Balt permit. Depart Import injury		Med a Da		147 Duke	of Gloud	ester S	t. Annapoli	s, MD 21401
Physician /Medical		23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.	he death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a, Hanging Due to (or as a conseinable)	quence of):					Death
	٦.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	nuence of):					
	Examiner	cause. Enter Underlying Cause		631.02.2	0-14 05098	25725		
tuted nd ransit		events resulting in death) Last Due to (or as a consert d.	quence or):					
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8760, tificate be ing physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom 1 Live birth	e of pregnancy 2	Fetal death	3 Ectopic pregr	nancy	23d. Date of delive Month	ery Day Year
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	ime of death 5	Other (Specify)				
P.O. Boy es that the death gned by the att		Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause	e given in Part I.		obacco use contribute	
ords, P.O. w requires that as been signed be should be detailed.	ed by					1Ye	Lance Lance	obably 4 Unknown autopsy findings available
COTC law red has bed e 2 shot	Completed					auto perfo	prior to prior to prior to death'	completion of cause of
Vital Rec tysician: The l his certificate l director, page	e Co	25. Was case referred to medical		26.Pla	ace of Death (Chec	1 Yes	2 No 1	Yes 2 No
1 of Vita ing Physicia After this ce funeral direct	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatier		tpatient 3 DOA		ing Home 5	Residence 6 🗸 Ott	ner: Scene
Division of Vital Records, tat or Attending Physician: The law require at a faire dealh. al Director: After this certificate has been sited in by the funeral director, page 2 should b	ion:	27. Manner of Death 1 Natural 5 Pending Pending 28a. Date of Injur	FOUI	ND: 1	njury at Work? Yes 2 ✔ No	28d. Describe Subject har	how injury occurred nged self	
Visior or Attend ther death birector:	Certification:	2 Accident Investigation Jul 7, 2008	ury - At home, far	m, street, factory, office	e building, etc.	28f. Location (Rural Route Number, City
Divi	Cert	4 Homicide determined (Specify) Sing				958 Highpoin	t Drive, Annapolis, I	
To the Hos within 24 h To the Fur	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of exam	knowledge, deat nination and/or in	th occurred at the time, vestigation, in my opini	date and place, ar ion, death occurred	nd due to the cau I at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
To Will	Me	29b. Signature and title of certifier		29c. Lice	ense number		29d. Date signed (M	Month, Day, Year)
		Jarly Geg nes		0.0	C.M.E.		July 8, 2008	
A BOOK		 Name and address of person who completed cause of de Tasha Greenberg MD. Assistant Medica 		111 Penn Stree	t, Baltimore, N	ND 21201		
S		31. Date filed (Month, Day, Year) 32. R distrar	's Signature	dead :				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vathaniel DINE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Months 1 X M 2 □ F Days 49 April 18. Maryland 219-68-3774 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Directo Maryland Prince George's Bowie 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 20715 8601 Racetrack Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: à 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Facility Supervisor Race Track 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiam; If Item 27 Is marked out Be George E. Green Helen E. Queen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8603 Racetrack Road Bowie, MD 20715 Joyce Green-Millner/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place National Harmony Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or once, 7/9/2008 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21, Signature of Funeral Service censee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) iffo de Taslasis **Physician** Me repalic /Medical Due to (or as a consequence of): Examiner forentia di ademocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (o as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) d by the at detached f 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed page 2 should peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 TYes certificate or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner? Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury 27 Manner of Death Certification: (Month, Day Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director; 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 🗆 Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

within 2 To the F

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Kebanoff, The Johns Registrar's Signature

JUL 0 9 2008

Medical

-000

600 North Wolfe St, Baltimore, MD, 21287

Hopkins Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robin Kay Hensley 12:50 A.^M July 18, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 406 Linganore Ave. Hagerstown Washington 8. Date of Birth
(Month, Day, Year)
Feb. 19,1962 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗗 F 220-82-8614 46 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at ¥ZYes 2 □ No Washington Hagerstown Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21740 U.S.A 406 Linganore Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 10 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patsy J. Wolfe Samuel K. Snyder Sr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 406 Linganore Ave. Hagerstown, Md. 21740 Michael L. Hensley (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 22, M Burial 2 Cremation 3 Removal from State Boonsboro Cemetery 2008 Boonsboro, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury MO1414 Jeffer J.L. Davis Funeral Home Smithsburg, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metasta VCCL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 은 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are.

To the Funeral Direct 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Registrar DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland

Hygiene.

Maryland 21215-0036

Baltimore,

the death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Hospital or Attending Physician:

0

29c. License number

41667

29d. Date signed (Month, Day, Year)

Dedical Comos thegenhous MO

and manner stated.

Meck

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 13:51 2008 Ruth E. Humphries 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Peninsula Regional Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs. 90 161-09-9573 Virginia Director Sept. 3, 1917 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show th and Menial Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinational to notified at Director 1 ☐ Yes 2 No DE Sussex Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 19940 6845 Hummingbird Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21XX No Specify: Completed by 3 X Widowed 4 ☐ Divorced white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withinment of Health and Mental Hygiene.
ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Nursing School Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Warrington John D. Elliott ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rehoboth Beach, DE 19971 Edwin J. Humphries Arnell Drive (Son) item 2 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. = ৳ July 9, 2008 Lewes, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Bethel 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street Signature of Funeral Service Licensee 19940 Delmar, DE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 TXNo detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

law requires that the death certificate be executed 68760 Box Ö Physician: The Vital ð Division or Attending death.

with

72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director; filled in by the Hospital

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifie (45049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAPITULI Street SALISBURY Md 21801 ChrisTophen Snyden 100 €. Do

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Degistrar's Signature

Registrar

6 Could not be determined

JUL 1 0 2008

3 Suicide

4 Homicide

31. Date filed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 11:00 A[™] Cathy L. Hess July 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Howard 800 River Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 □ X 07-15-42 65 Director 215 40 0688 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he activity once. 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Director MD Sykesville Howard 10g. Citizen of What Country? 10e. Street and Number 21784 United States 800 River Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ Year or Dates: 3 □ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Lithographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Angelina Bertucca James Guyaux 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 644 River Road Sykesville, MD 21784 James A. Hess/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-14-2008 Hanover, MD Ardent Crematory 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Obstructive Relimoner Gears hronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work?

The law requires that the death certificate be executed P.O. Box 68760. Records, Division or Vital Hospital or Attending

Maryland 21215-0036

Baltimore,

Medical Certification:

Director:

De lean 31. Date filed (Month, Day, Year)

1 X Natural

2 Accident

3 Suicide

29a. Certifier (Check only one

4 ☐ Homicide

29b. Signature and title

and manner stated.

29c. License number

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

21044

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 14, 2008

Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little

5 Pending investigation

6 ☐ Could not be

2008

strar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

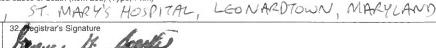
68760, Box Ö Records, Vital Division or

> State Registrar

31. Date filed (Month, Day, Year) 11 2008

JOHN HARVEY

29b. Signature and little of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2008 Irene E. Holt 9:15 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4722 Sands Rd. Harwood Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | N 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Maryland Year) 5 1917 1 □ M 2 □ ₩ Sept Director 218-20-0180 90 Usual Residence of Decedent the Maryland 10a. State r items 23a or 28a-f show inscrives be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, its Modical Examination is used to a 4722 Sands Rd. 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 Completed by 1 ∐Yes 2 ∐WNo Specify: Black ¾☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Housewife None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Fletcher Christine Perry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Holt(Daughter) Dukeland St. Baltimore, Md. 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adams UM Church 7-8-08 Lothian, Md. 21. Signature of Funeral Service Licensee Winname Rocked Best Sons Mortuary, P.A. Jarry B 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ta:lure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dementio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ hypertens: or Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should certificate 2 Be Medical Certification: To this After th funeral 2 he Funeral Director: Af

Box 68760, P.0. Division of Vital Records,

Cerebro vasc.	clar disease			24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	ome 5 Residence 6	G ☐ Other (Specify)	
7. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati	the second second second second	28b. Time of Injury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	/ occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factory,	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,	
29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my kno aminer: On the basis of examina	owledge, death occurred a ation and/or investigation,	at the time, date and place, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

D40210

29d. Date signed (Month, Day, Year)

7-7-08

State

completely within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leslie F. Brooks West River, MD 139 Owensville Rd

31. Date filed (Month, Day, Year)

29b. Signature and title

32 Registrar's Signature 0 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 9:55A M ICKMAN 06 2008 JULY /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BURNIE ANNE ARUNDEL WASHINGTON NEDICAL CENTER EN 8. Date of Birth (Month, Day, Year) April 3,1936 Baltimore, MD 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 □ F Months Davs Hours 216-34-8124 72 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at MD Anne Arundel Millersville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8049 Veterans Highway Rol Park 31 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1955-Black, White, etc. 72 hours after 1 Never Married 2 Married White If Yes, Give Year or Dates 1957 1 □ Yes 2 🗷 No Completed by Specify Specify. 3 X Widowed 4 □ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Executive 2 Elementary/Secondary (0-12) College (1-4or 5+) Insurance 12 02 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hickman Walter Creston Martha Allen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8049 Veterans Highway Rol Park 31 Millersville, MD Tusing Companion Anna Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 7/8/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore,MD 21. Signature of Funeral Service Licensee P.A. Hardesty Funeral Home P.A. 851 Annapolis Road Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **hysician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and numar the attending physician and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNO 1 □Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1, Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) D003274L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD MARIA GAV 21061 301

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

0 9 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 2008 Month P^{M} JEANNINE IRLE JUL 9:47 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1 □ M 2 🖫 F Months July 28, 1932 Paris, France 555-62-2336 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 □Yes 2□No Virginia Falls Church Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7024 Strathmore Street . S . A . 22042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2x No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Chief Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Marie Herve Marie Rose Hamet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7024 Strathmore Street, Falls Church, VA 2204 e of Disposition (Name of Date 20c. Location - City or Town, State Harry Lee Irle(Husband) VA 22042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery 7/28/08 Arlington, Virginia 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046 CC0330 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS

Physician /Medical **Examiner**

death certificate be executed

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending

death.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

notified

ms 23a or

Director

Funeral

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Completed

Be ဥ

with the Maryland

filed within 72 hours after death v Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Inportant; I fam 27 is marked other than "natural", or Items: any Injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

burial-trar physician this funeral After 1 within 24 hours af er deat To the Funeral Director. by filled

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 1 1 2008

ROBERT F. BROWNING

30. Name and address of person who completed cause of deat (12 m 23a) (Type, Print)

CDR

MC

32. Registrar's Signature

		Due to (or as a consequence or).	i i
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pilsease or injury that initiated events	b. Due to (or as a consequence of):	20
edical Exa	resulting in death) Last	Due to (or as a consequence of):	
ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
ed by Pr	Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown	
Comple			24a. Was an autopsy performed? 1□ Yes 2√√2 No 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No
D D	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury 28b. Time of 28c. Injury at 2 2 2 2 2 2 2 2 2	28d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	t8f. Location (Street and Number or Rural Route Number, City or Town, State)
lical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exal	nysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

D-64164

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

USN

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** Tuly Alvon Juseph 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Hospital at Easton Easton, Memoria If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1 M 2 □ F 219-36-6510 Usual Residence of Decedent 40 **Director** Maryland 6 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Wes 2 □ No by Funeral Director Talbot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 14. Race - American Indian, dier Vana 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) river 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ears Johns P eorge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton, Maryland 21601 rnest 53-Manadier Rd. ham Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State een Esther Cemetery: 7
22. Name and Address of acility
Henry Funeral 7/15/08 4 ☐ Donation 5 ☐ Other (Specify) Easton, Maryland 21. Signature of Funeral Service Licensee Home, P.A. anell Cambridg MD.21613 510 washington st 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due tur as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a..
autopsy
performed?
Yes 2 1 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Accertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/10/08 762

State

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

54

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Amend #18, 7-1	4-08, per FHDR,	Certificate of D	eath	Reg. N	.2008	24096	
· · ·		1. Decedent's Name (First, Middle, Last)					ay Year	3. Time of Death	
Physic /Medi		Ingeborg Kassaraba				July 10,		10:30 A M	
Exami		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or L	ocation of Death	1	c. County of Death		
1 "		6370 Euclid Avenue		Elkridge	If Under 24 Hrs. 8		loward	place (State or Foreign	
Funeral Director		325-60-9202	M 2XF 7. Age (In yrs. last birt	Hours Min.	3. Date of Birth (Month, Day, Yea Aug 10, 1	944 Nort	ntry)		
pur »	7	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	-			10d. Inside City Limits	
Aarylan f show	٥		On infi	1.4				1XTYes 2 ☐ No	
the the table to table t	rec	MD Somer set	Crisfie	10f. Zip Code			Citizen of What Cou	intry?	
3a or	Funeral Director	9 Columbia Avenue		21817		Nor	way		
death ms 2	ner	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Amer Black, White		
after a		1 ☐ Never Married 2 ☐ Married	1 ☐Yes 2 ☒ No If Yes, Give	1 □Yes 2 No	Specify:		Specify:	140	
ural",	d by	3 ☐ Widowed 4 ▼ Divorced	Year or Dates:	Description House Occupa	tion	16h	Kind of Business/I	ndustry	
"nat	Completed	15. Decedent's Educa (Specify only highest grade	ation	Decedent's Usual Occupa: (Give kind of work done du life, DO NOT use retired)	uring most of working		THIS OF ECONOCION		
withir ene.	l mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Al Estate	AGENT	R	EALES	tAte	
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or Items 23a or 28a-f show umatic event, the "sadical Examinar must be notified at		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Surname)		
id be lental ked o	To Be	ARNE Almhie	.11		DAGNEY	- Dagny		(unK)	
and N	-	19a. Informant's Name/Relationship (Typ	ne. Print) 19b	. Mailing Address (Street a	nd Number or Rural			ip Code)	
1 and 2 Health a em 27 is		VIVIAN Thompson	Idaughter 6	370 Eucli				21075	
of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	cemeter	f Disposition (Name of ry, crematory or other place	Da		Location - City or		
Pages ment of ant: If it		4 □ Donation 5 □ Other (Specify)	Chest	PEAKE Cremm	ORY 07/1	4/08 B	eltsville,	MD_	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "hodical Examinar must be notified at once.		21. Sign sure of Funeral Service License	e 0 11	22. Name and Address	s of Facility mati	on Service	ce Poji	301.734	
1 %OE % 6	R	Devery To Ho	elette MOI 251	BEVERLY LI	HECKTOTTE	PAC	AR KSU-11E	Approximate	
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do le cause on each line.	not enter the mode of dying	g, such as cardiac of	respiratory arrest,		Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition resulting in death)	Breast CANCER	metrothic to	hver, bo	NE, lung		21 YEARS	
/Medical Examiner		resulting in death)	Due to (or as a consequence	of):					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence						
uted J ansit	J.E	Cause (Disease or injury	G						
exection and ital-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	U d							
rtifica ng ph as th	Jed	IF FEMALE:							
ath cel	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	n 3 ☐ Ectopic pregnancy	/		23d. Date of de Month	livery Day Year	
e dea the at	sici	1 ☐Yes 2, ☒No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)					
rat the	Phy	Part II. Other significant conditions con	stributing to death but not resulting i	n the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
ires the signer signer of the contract of the	by	ANEMIA, LIVER FI				1 ☐ Yes	2 □ No 3 □ P	robably 4 🗆 Unknown	
law requires as been sign 2 should be	Completed	The training				24a. Was an	24b. Were a	utopsy findings available	
ne law e has ge 2 g	ld m					autopsy performed	prior to death?	completion of cause of	
ding Physician: The law requires that the death centh. After this certificate has been signed by the attendifuneral director, page 2 should be detached for use	ပို	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2	No 1 ⊔ Yes	s 2 No	
Physician: r this certificaral director, p	o Bé	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Othe	or:	me 5 Residenc	e 6 Other (Spe	daughters	
g Phy er this		27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury Work	y at	28d. Describe how	injury occurred		
ath.	atio	1. Natural 5 Pending 2 Accident investigation	(Monon, Day, rear)		Yes 2□No				
Incompleted of the function of	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	1	28f. Location (Stree City or Town, S	et and Number or Fi State)	lural Route Number,	
ital o ral Di	Se					and does he about	and mannor (as stated	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ical	(Check only 2 Medical Examin	sician: To the best of my knowledg ner: On the basis of examination a	ge, death occurred at the tir nd/or investigation, in my o	me, date and place, ppinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)	
thin 2 the i	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens	e number	29d	. Date signed (Mon	th, Day, Year)	
7 .≱ 5 .8	_	De N M	Thomas			-	- N 10 3	1003	
		30. Name and address of person who co		(Type, Print)		J	417 10,0		
(0) ad	,	JON K. Minfo	ed M.A. 1100	5 WHIE PA	HUXENT F	KWY . Co	lumbin. 1	008 MD 91044	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature			7			
Regis	strar	1111 1 4 2	MARINE B	Marke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 28, 2008 5:45 аМ May DEOVAR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 309 East Village Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Months Pennsylvania 11X M 2 ☐ F Yrs. Ĩ930 77 July 12, 187-24-7069 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 1 Yes 2 No Elkton Director Maryland Cecil 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 309 East Village Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1951-54 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 end 2 should be filed within 7:
Deportment of Heelih and Mental Hyglene.
Important: if Item 27 is marked other than "ns eny injury or other traumatic event, the Medic once. Thiokol College (1-4or 5+) Two Years Elementary/Secondary (0-12) Elkton, Maryland Security Guard 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ruth Makin Lowe George M. Kennedy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 East Village Road, Elkton, Maryland 21921 Ruth Ann Kennedy (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Grove United Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/01/08 Peach Bottom, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal ire of Funeral Service Licensee Methodist Church Cemetery 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End)tage **Physician** x104V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physiclen and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes ② ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes page 2 autopsy 1 ☐ Yes 2 ☐ No Olon (an (8 1 ☐ Yes 2 JN6 Physician: After this certification funeral director, p 25. Was case re erred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō Hospitai 🎨 Gartifyling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated 29a. Curtiflor Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier LOW would 30. Nam and address of person who completed came of death (Item 23.1) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 3008 Scott Edward Lowery 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 🗷 M 2 🗆 F District of Columbia April 15, 1958 220-70-6532 50 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21229 1000 Arion Park Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lockheed Martin Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Constance Marie Pelikan James Richard Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2408 Wilkins Avenue, Baltimore, Maryland 21223 Steven Lowery - Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 07/16/2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Modin T. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zyears ESOPHAGEAL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If ves. outcome of pregnancy 23d. Date of delivery Month Day Year

29d. Date signed (Month, Day, Year)

JULY 7, 2008

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the ORCE.

Physician

/Medical

Examiner

10a. State

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Funeral

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examination of Demolities at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

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Physician/Medical

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Certification: To

ical

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and attending physician a for use as the burialthe à s been signed to should be deta has this certificate

that the death certificate be executed Hospital or Attending Physician; in 24 hours after death.
Ihe Funeral Director; After thi
npletely filled in by the funeral I the To the within To the

in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year							
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown							
		24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	I. Describe how injury occurred							
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)							

900 SOWH CARN AVENU

32 Registrar's Signature

State Registrar 29c. License number

D 2264F

BALTIMORE MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 10:00 P M 05, 2008 Robert Bryan Lantz 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel 257 Providence Road Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 XM 2 ☐ F 72 286-30-1361 Jan. 11,1936 Ohio Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County MD Anne Arundel Annapolis 1 ☐ Yes 2 → No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 257 Providence Road 21409 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1965-If Yes, Give Year or Dates: 1971 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2▼No Specify: White Specify: 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Institute of Pastoral Counseling, Elementary/Secondary (0-12) College (1-4or 5+) Pastoral Counselor 5+ Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy M. Wetherbie William Bryan Lantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine I. Lantz/ Wife 257 Providence Road Annapolis, MD 21409 20b. Place of Disposition (Name of Cemetery, crematory or other place) Historic Christ Church 20c. Location - City or Town, State 20a. Method of Disposition July 1 X Burial 2 ☐ Cremation 3 X Removal from State Irvington, VA 2008 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) P.A. 495 Gov. Ritchie Hwy, 21. Signature of eral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 P.A. low Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part <mark>il. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 2 **N**O 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner Physician/Medical certificate has been signed by the rector, page 2 should be detached þ Be Completed this certifical director, Certification: To After after death Director: / i 24 hours aft e Funeral Di letely filled in

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the We dieal Examination to outlind a once.

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred JENatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated.

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completely

within 2

State Registrar

Medical

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Pri

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APRIL TIPH#291 per HYS . 081 . 7/25 / 08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month D'8 MATLOON William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perring Barkwaz Baltomorp Giresis Yarkuille | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April Apr 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 4,1930 X□M 2□F Yrs Director 218-26-9206 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21234 1801 Wentworth Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must I once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Attendant Parking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LaFayette Mattoon Emma Boston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9415Flagstone Drive,Baltimore,Maryland 21234 Anna Sheridan/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-2-08 Baltimore, Maryland 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A. michael marguelle 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Prevmen days /Medical Due to (or as a consequence of): **Examiner** Due to (¹r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last 50 burial-tran Division or Vital Records, P.O. Box 68760, े Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dm H 524 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 3/195 7/1/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700000 Wendy Jacobse 31. Date filed (Month, Day, Year) 6 701 N Charles St 7202 21204 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Month Sarah Gene Murin May 29, 5:20 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil Elkton Abbey Manor Assisted Living | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03/27/1926 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🔀 F 178-20-2299 82 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Butler 1 ☐ Yes 2X No PAButler 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 119 Murin Lane 16002 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 🔀 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Conrad Juliet Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kelly Murin / Son 1003 Jackson Hall School Road, Elkton MD 21921 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition United Crematory or other pla 3 □Removal from State 1 ☐ Burial 2 X Cremation Newark, DE 05/30/2008 4 ☐ Donation 5 ☐ Other (Specify) Services ²² Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 21. Signature of Funeral Service Licens Clian Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was cas examine 1 🗌 Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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other traumatic event, the Medical

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be filed within 72 hours after ntal Hygiene.

Examiner Physician/Medical Completed by Be Medical Certification: To

27 Manner

the burial-tra attending physician for use as the burial cate has been signed by page 2 should be detacl certificate funeral director, this. 4 hours af er death.

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 □ Pregnant at time of death	5 Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Pa

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1 XNatural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 🗆 No	200 Doconto Non Injury Communication	2000
3□ Suicide 4□ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rur City or Town, State)	al Route Number,
29a. Certifier						e, and due to the cause(s) and manner as	

(Check only 2 Medical Exam	iner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s
b. Signature and little of certifier		29c. License number	29d. Date signed (Month, Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print MONSOV

State Registrar

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thin 24 hours at the Funeral E Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July Lacev McKinney 2008 8:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 4215 Kolb Avenue Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 M 2 □ F Months Days Hours Min 546-38-7807 86 Director 1922 Apr 26 Alabama Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, Inc. Moden Examinar miss to a militar at Director Maryland Anne Arundel 1 ☐ Yes 2 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 Crain Highway North 21061 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them?" any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates: W.W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2√∑ No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) 12th Barber Defense 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnnie McKinney Mary Mann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,0\,6\,1$ Geraldine McKinney(Wife) 918 Crain Highway North Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veteran 17-8-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mame Andres of Sacillo ons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annappolis, Md. 21401 11009 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a constitution of The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performe 2□No 21 No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 5 Other (Specify) 1 ☐ Yes Hay 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this မ 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Mann Death Medical Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 atural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determine 3 Suicide Se. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year

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Name and address_of person who completed cause of death (Item 23a) (Type, Print) M-D

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Annapolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^D2008 **Physician** July 9, 8:25 a M Frank Nana Megargee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 305 Mallard Landing Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 164-16-9078 Director 7/10/1917 Pennsylvania 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County show s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
The first 71 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Marical Event from the traumatic event, the Marical Event from the traumatic event, the Marical Event from the continued and the continu 1 TYYes 2 □ No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 305 Mallard Landing Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Army If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white 2 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Sun news reporter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Greene Frank Nana Megargee Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 723 Genessee St., Annapolis, MD 21401 Ann M. Palmer/daughter permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Andrews Episcopal Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Arm Church 7/12/08 Princess Anne, MD Signature of Funeral Service Licensee Name and Address of Facility HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 hompoor ONTO CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Undersorts that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy detached for Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 32. B

5. DIVISION Show

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar AMEND#17perFH7-17-08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9, 2008 7:20 A^{M} Ju1y Eleanor Redwood Penovich 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 7, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Days Hours 1 □ M 2 1 F 228-32-8676 82 Asheville, NC 1926 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Md Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5100 Dorset Ave Apt. 213 U.S.A. 20815 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1∐Yes 2⊠No Specify: Specify: 3 → Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Volunteer Charities 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last)
Robert Lee Redwood Robert -Penovich Sophia Garlick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3109 Lee St. Silver Spring, Md 20910 John Penovich - son 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 11,08 Falls Church, Va. 4 □ Donation 5 □ Other (Specify) National Crematory 22. Name and Address of Facility JOseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee Willia 5130 Wisconsin Ave N.W. Washington D.C. 20016 t Jused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, och line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea A., or complications the shock, or heart failure. List only one cause Immediate Cause (Final Seven Days Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ∐Yes 24DXNo 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital:

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner is ust be notified at

7 is marked other traumatic event, 11

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked oth any injury or other traumatic event once.

Director

Funeral

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21215-0036

Baltimore, Maryland

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Hospital or Attending Physician: The law

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Vital

Division of

Examiner Physician/Medical ð Be Completed Medical Certification: To

in the past 12 months? 1 ☐ Yes 2 🏝 No 9 Unknown

Atrial Fibrillation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1∐Yes 2∐¥No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide

4 Homicide

29a. Certifier

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated. 29b. Signature and title of certifier Michael Worteman

29c. License number D52451

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) July 9, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Westerman M.D. PO Box 2316 Kensington, MD 20891

State Registrar 31. Date filed (Month, Day, Year) JUL 11 2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JACK D. PERRY JUL 6 2008 2:18 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**) M 2□ F $81^{\,\mathrm{Yrs}}$ 324-20-5266 July 05, 1927 Director Missouri Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Tx Yes 2 □ No traumatic event, the Medical Examiner must be notified Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 901 Leverton Road 20852 United States Funeral 14. Race - American Indian or items, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1948-70 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Lietenant Colonel U.S. Army _ should be filt. Ifth and Mental Hvi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence 0. Perry Lucille Α. Fortune ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Linda Perry / Spouse 901 Leverton Road, Rockville, MD 20852 Department of He. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 7/11/2008 4 Donation 5 Dother (Specify) Brentwood, MD 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disea shock, of eart failure Immediate Course (Final disease or condition resulting in death) Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Physician PANCREATITIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day ò Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown certificate has been signed by rector, page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2♥ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 🔀 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ospital or Atter.
44 hours after death.
••••al Director: Afte 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certific

Hospital

72 hours after

executed

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Box 68760

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Division or Vital Records,

3altimore, Maryland 21215-0036

State Registrar

BROWNING ROBERT F. 31. Date filed (Month, Day, Year) JUL



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

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amend line 19a per fd aaco hlth dept 07/16/08 dlw
1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or

State

Print in Black Indelible link. Ensure All	Copies Are Legiple	21.	INC
of Maryland / Department of Health and M	lental Hygien & UUO	24	100
Certificate of Death	Reg. No.		

2. Date of Death

3. Time of Death

2008

21201

Physician /Medica

Examine

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Informative it items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Modeal Eventual or other traumatic event, the Modeal Eventual or other pages. Baltimore, Maryland 21215-0036

Pierce

Takes

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

VAMES WILL	AM PIERCE				07	07	2008	1-44PM
4a. Facility Name (If not institution, giv	e street and number))	4c. Cou	nty of Death				
Baltimore Washing	ton Medical Cer	nter		Burnie		Ann	e Arun	
5. Social Security Number 6. S 226–48–1441	ex 7. Age (In yrs. I. X M 2 □ F 70	ast birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24 Hrs. ys Hours Min.	8. Date of Bir (Month, Di 5/10	71938	9. Birthp Cour	place (State or Foreign offry) DC
Usual Residence of Decedent								Od Ingida City Limita
10a. State 10b. County Anne Ar		, Town or Loca Gamb r					[]	0d. Inside City Limits 1 ☐ Yes 🛣 No
10e. Street and Number			10f. Zip Cod	le		10g. Citizen	of What Cour	ntry?
2404 Maytime Dr.			2	21054			USA	
11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No	0- 14.	Race - Americ	
4 □N M								hite
15. Decedent's Ed (Specify only highest gra	ducation	16a. Decede	ent's Usual Oc	ccupation one during most of wor	kina	16b. Kind o	f Business/In	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	tired)	King		USAF	
17. Father's Name (First, Middle, Last, James Pierce)			18. Mother's Nan Franc	ne (First, Middle es Stub		name)	
19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (St	reet and Number or Ru	ıral Route Numb	ber, City or To	wn, State, Zip	Code)
Doris J. Pierce	TCE Spouse	2404 M	laytime	Dr. Gambr	ills, M	D 2105	4	
20a. Method of Disposition *22 Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Disposi	ition (Name o	f place) as Cem 7/14	Date / 2008		on - City or To	
4 □ Donation 5 □ Other (Specif				ddress of Facility Har				
21. Signature of Funeral Service Licer	Daulisty 8			ely Ave. A				r.A.
23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				or respiratory a	arrest,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	a. /// Y Due to (or as a consequ		IFAR	TION			A	MINUTES
Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying	b Due to (or as a consequ	uence of):						
that initiated events	C							
resulting in death) Last	Due to (or as a consequ	ience of):):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 🗌	Ectopic pregr Other (specif			23d.	Date of deliv Month	ery Day Year
Part II. Other significant conditions	contributing to death but not resu	alting in the und	derlying cause	given in Part I.	23e. Did	tobacco use o	contribute to t	he cause of death?
CONGESTIVE	HEART FA	LURE	5		1 🗆	Yes 2 N	o 3□ Pro	bably 4 🗀 Unknown
DIABETES A	NELLITUS				perf	s an 2- opsy formed? 2 No	4b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?				26. Place of Dea				
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							ify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) lnj			Injury at Work? 1 □Yes 2 □ No	28d. Describe	how injury oc	curred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		me, farm, stre	reet, factory, office 28f. Location (Stree City or Town, S			(Street and Nown, State)	umber or Rur	al Route Number,
	nysician: To the best of my kno- miner: On the basis of examina and manner stated.							
29b. Signature and title of certifier			29c. Lie	cense number		29d. Date si	gned (Month,	Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUL 1 0 2008

ouced May MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0032186

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2008 6:02 Рм **Physician** John Abreu Perry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 10, 10) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Social Security Number **Funeral** 1921 Massachusetts Director 019-18-5281 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes XX No **Funeral Director** Port Republic Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20676 1995 Wash Hance Road 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1.04.6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 KN es 2 No 1949—
If Yes, Give
Year or Dates: 1960 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 🗖 o Specify: White Be Completed by XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Chief Petty Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it and 2 should be fill Health and Mental H tem 27 is marked ott Caridade Pestana 2 Antonio Pereira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1995 Wash Hance Road Port Republic, Maryland 20676 Kathy P. Smith / Daughter Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages ' 1 Nurial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland Crownsville Vet. Cem. 7/11/2008 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee mil 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a card line. Immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (or as a consequence of): **Examiner** ASDITUTION Sequentially list conditions, if any, loading to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the D46419 and address of person who completed cause of death (Item 23a) (Type, Print) 404 Charles St La Plan, MD 2064C harleul A 31. Date filed (Month, Day, Year) State 0 9 2008 Registrar

DHMH 17 Rev 1/2001

Box 68760.

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Maryland 21215-0036

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pe page funeral director within 24 hours after death. To the Funeral Director: A the in by filled å.

State Registrar

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Journalus, D.O.

29c. License number 40066064 29d. Date signed (Month, Day, Year) 107/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Head Hospital Center, Salisbury, MD TONY GENSALVES Deers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:45 P M 07 20 2008 Verna Lindsay Ryan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oak Crest Village Retirement Center Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔽 F 90 Director 5/19/1918 Maryland <u>218 03 6116</u> 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Maryland Baltimore Director Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8832 Walther Blvd. 21234 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3√2 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Heatth and Mental Hygiene Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil service/US Gov Secretary 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Lester R. Lindsay Pearl E. Lay Pages 1 and 2 should Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3818 Belmont Drive, Jarrettsville, Md. 21084 Patricia Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐Removal from State St.Paul's Lutheran 4 Donation 5 Other (Specify) 7/24/08 Aberdeen, Maryland Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, Maryland 21001 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? Yes 2 No After this certificate 1☐ Yes or Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Horsing Home 5 Residence 6 Other (Specify) 2 N6 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud Parkville, MD 21234 MO 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Records, P.O. Box 68760,

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signed by the attending physician and be detached for use as the burial-transit cete has been sig page 2 should b this certificate Division of Vital funeral director, After 1 completely filled in by the

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be anothered as

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State Registrar

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of person who impleted cause of death (Item 23a) (Type, Print) 30. Name and address

31. Date filed (Month, Day, Year)

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203 SHOW ST. SHOW HILL, MD. 21863

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ŧ			a. Facility Name (if			et and number)		4b. City, To Germa						tgomer	/	State or
	Funeral Director	- 1	5. Social Security N		6. Sex	2X F	ge (in yrs. last		If Under Months		If Under 2 Hours	16-	9/9/1		For	reign Country)	NY
	w any	Ī	Usual Residence of 10a. State MD	Decedent 10b. County Montgo	omery		10c. City, To							10d. Inside City Limit			
M	Maryland r 28a-f sho	Director	10e. Street and Nu		ler 0	ourt			10f. Zip	Code			10g. Citizen of What C			tates	
125	Baltimore, MID 21219-10030 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Menalt Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 X Never Marri		arried 12	. Was Deceder Armed Forces			Was Deceder If Yes, specify	nt of Hisp Cuban,	Mexican, I	n? (Specit Puerto Ric	fy Yes or N an, etc.)		White		
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	Z 5-U be filed w antal Hygie rked othe	Be Co	17. Father's Name Alfred	Richman	n	Dist.)		Tah M	ailing Address	- 1	Shei	ila R	eiser			State, Zip C	Code)
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i	Balti permit. Departn Import						and the death	- 1	Chapel	s IT	170 I	Rockv	ille	Pike	Rock	ville	MD 208 proximate Inter etween Onset a
(hysiciar ledica xamine	1	23a. Part I. Enter failure. List of Immediate Cause or condition resul	only one caus e (Final diseas	e a.Ox	implications that caused the death. Do not enter the mode of dying, such each line. a. Oxycodone & metadone intoxicati Due to (or as a consequence of):											Death
		iner	Sequentially list of if any, leading to cause. Enter Uni	immediate	e	b. Due to (or as a consequence of):											
8	cecuted 1 and 1 transit	Examin	(Disease or injury events resulting i	y that initiated	D	ue to (or as a co					001	7/21	/00 m	n		-	
	50, te be execu iysician and	sician/Medical	X UNPENDE	ED		AMENDED 2			, per	1E, {				23d	. Date of o	delivery Day	Year
	Box 68760, e death certificate be the attending physic	ician/	23b. Was decede past 12 mon				nt at time of de	2 eath 5	Fetal deat		Ectop	ic pregnar					
	P.O. Bost that the deargned by the a	by Phys	Part II. Other sig			g Unknow		esulting i	n the underlyi	ng cause	given in F	Part I.					cause of death y 4 🗸 Unkno
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.	Completed b							***				a	Vas an autopsy performed?	6	Vere autoportion to compleath?	sy findings ava pletion of cause 2 N
	I Rec in: The l	or, page		eferred to med						1	ce of Deat		only one)		once 6	Other: Se	cene
	of Vita ig Physicia fter this ce	Tuneral directo	1 V Yes	2 No Death	H	28a. Date o	patient 2 of Injury Day, Year)		patient 3 ime of Injury	DOA 28c. Ir	njury at Wo	ork?	28d. Desc unk	cribe how in			
	Division of Vital Records, tal or Attending Physician: The law requirers after death.	by the	1 Natural 2 Acciden 3 Suicide	nt In	ending evestigation	7/15/ 28e. Place	08 Fnd of Injury - At	home, far	5 pm	ory, offic	_	etc.	28f. Local	tion (Street wn, State)	20260 MD	er or Rural	Route Number
	Division Hospital or Attend 24 hours after death. Funeral Director:	Certifying Physician: To the best of my knowledge, death occurred at the time.							to the cause(s) and manner as stated.								
4	To the I within 2	compl	one) 2 29b. Signature			and manner st	ated.				ense numb			29d	. Date sign	nea (Monu	n, Day, Year)

29b. Signature and title of certifier

Pamela E. Southall, MD 32 Kegistrar's Signature 31. Date filed (Month, Day Year) 2008 State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 16, 2008

			Please Type or Print State of M 1 - State Registrar 1. Decedent's Name (First, Middle, Last)	aryland / D	epartmen	e Ink. Ensure It of Health and It of Death		rgiene 20	0 8 2 4 1 1 2
	Physici /Medi		Robert F Ro	binsoi	7		July Month	7 ^{Day} 200	R QUSP.M.
24	Examir		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or Location of De		4c. County	
1	Funeral		5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birth		en Burnie, 1 Year If Under 24 F	rs. 8. Date of Bi	rth	Arundel 9. Birthplace (State or Foreign
	Director		295 20 862 1 M 2 F Usual Residence of Decedent	~ 4 -	rs. Months	Days Hours N	in. (Month, D	ay, Year) 27,1923	Birthplace (State or Foreign Country) OHIO
	aryland show	-	10a. State 10b. County	10c. City, Town	or Location		1-		10d. Inside City Limits
	28a-f	Director	MD Anne Arundel 10e. Street and Number	<u></u>	10f. Zip	Severna I	ark	10g. Citizen of W	1 □Yes 2 ☑ No
	h with	al Di	114 Roads End Lane		101. 210	21146			JSA
21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show offical Exaction Linest be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 ☒ Yes 2 □ If Yes, Give Year or Dates:	?	13. Was Deced	dent of Hispanic Origin? cify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or N erto Rican, etc.)		- American Indian, K, White, etc. White
15-0	72 hc "natur	letec	15. Decedent's Education (Specify only highest grade completed)	1 (Decedent's Usua (Give kind of wor	rk done during most of t	vorking	16b. Kind of Bu	siness/Industry
212	I within jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5		Plant M			Food	Processing
	be filed ntat Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)				lame (First, Middle	e, Maiden Surnam	9)
Maryland	Mer Mer arke	은	George Raymond Robinson			Doris			
	s 1 and 2 sho of Health and Item 27 Is ma other traums		19a. Informant's Name/Relationship (Type. Print) Marjorie A. Robinson/Wife	11	4 Roads	(Street and Number of End Lane,		Park, MD	21146
Baltimore,	Peges 1 nent of H nt; if Itea ry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name, crematory or		uly 9 , 2008	20c. Location - Baltimo	City or Town, State
Balti	permit. Peges 'Department of Important: If Ite any Injury or of once.		21. Signature of Puneral Service Licensee		Barran 495 Go	d Address of Facility CO & SONS, V. Ritchie	1 2 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	erna Parl erna Parl	k Funeral Home k, MD 21146
60,	ate be executed / Medical invision and purial-transit per burial-transit per prize per per per per per per per per per pe	lical Examiner	shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as c	a consequence of	Aen millert	od dise	<u>se</u>		Interval Between Onset and Death
. Box	ires that the death certificate by signed by the attending physical be detached for use as the bit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown 9 Unknown 1 Unknown 1 1 1 1 1 1 1 1 1	2 Fetal death	3 ☐ Ectopic pi 5 ☐ Other (sp			23d. Date Mos	e of delivery tth Day Year
ds, F	The law requires that the ate has been signed by thoage 2 should be detache	ρ	Part II. Other significant conditions contributing to death b	ut not resulting in t	the underlying ca	ause given in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
COL	w requ	letec	to 1 2/2 - 2 4	1	2616	, <u>a </u>	24a. Was		Vere autopsy findings available
0	00 00	_	Well Assured 12	10 11.00		-	auto	opsy p ormoed? d	rior to completion of cause of
a B	icate h	Completed					1 □ Yes	2 110	eath? □Yes 2□No
Vita	sician: The certificate hi irector, page	Be	25. Was case referred to medical examiner? 1				Death (Check only	one)	□Yes 2□No
of Vita	Physician: this certific	To Be	examiner? 1 Yes 2 No Hospital: 11 Inpatie 27. Manner of Death 28a. Date of Inju		me of 2	Other: 4 Nursin	Death (Check only) Home 5 Res	one)	□Yes 2 □ No
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vision of Vita	ding Physician: h. After this certifica funeral director,	To Be	examiner? Yes 2 No	ury 28b. Tii	me of jury M	OA Other: 4 Nursin 8c. Injury at Work? 1 Yes 2 No	Death (Check only Jean Solution Check only	one) idence 6 □Othe how injury occurre	□Yes 2 □ No
vision of Vita	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, to	Certification: To Be	examiner? Yes 2 No	ury - At home, farm c. (Specify) of my knowledge, of examination and	me of jury M m, street, factory, death occurred	OA Other: 4 Nursin 8c. Injury at Work? 1 Yes 2 No c office	peath (Check only g Home 5 ☐ Res 28d. Describe 28f. Location City or To	idence 6 Other how injury occurrence (Street and Number win, State)	er (Specify) ed er or Rural Route Number,
vision of Vita	l or Attending Physician: after death. Director: After this certific. d in by the funeral director,	To Be	examiner? Yes 2 No	ury - At home, farm c. (Specify) of my knowledge, of examination and	me of lury M 2: m, street, factory, death occurred for investigation,	OA Other: 4 Nursin 8c. Injury at Work? 1 Yes 2 No c office	peath (Check only g Home 5 ☐ Res 28d. Describe 28f. Location City or To	idence 6 Other how injury occurre (Street and Number wn, State) e cause(s) and ma , date and place, a	er (Specify) and er or Rural Route Number, nner as stated. and due to the cause(s) (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20	08	24		13
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		1- For State Registrar Certificate of Death	Reg.	No.	
Physician	1/		Date of Death Month D	ay Year	3. Time of Death
ledical Examin			July 7, 2008		1612 hrs
		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death Glen Burnie	231	4c. County of De Anne Arund	
Funeral	- 1			TEO	Birthplace (State or eign
Director	- 1	017-44-0772 1X M 2 F 55 Yrs. Months Days Hours Min.	8/19/19	952	Country) MASS
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<u>*</u> .	ے ا	MD Anne Arundel Odenton			1 Yes 2XX No
the N	2	10e. Street and Number 1005 Samantha Lane #103 10f. Zip Code 21113	10g	. Citizen of What C USA	
items 2	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No		14. Race - An White, etc	nerican Indian, Black, c.
fter d		3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify:		Specify:	White
ours a	۹ ا	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wor		6b. Kind of Busine	ss/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiène Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Vice Predident	۵)	Telecomm	nunications
21215-0036 build be filed within 7 Mental Hygiene. marked other than re event, the Medica	탉	17. Father's Name (First, Middle, Last) 18.Mother's Name (F	irst, Middle, Ma	iden Surname)	
215 be file ntal H rked cnt, tl		Lawrence J. Raleigh Lorraine	Murphy		
21 nould and Meris man	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rule)			
MD td 2 sho	- 1	Meredith R. Raleigh Spouse 1005 Samantha Lane #10		nton, MD	
ore, in		20a. Method of Disposition 1 Burial 2 XXcremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	y or Town, State
Page nent or out		4 Donation 5 Other Specify: Metro Crematory 7/10		Baltimor	
Baltimore, permit. Pages I ar Department of Hee Important: If the njury or other tr	1	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hard			
	4	12 Ridgely Ave. Anna	apolis,	MD 21401	
Physician /Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r failure. List only one cause on each line.	espiratory arres	it, snock, or neart	Approximate Interval Between Onset and
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
	-	b bac to (or as a consequence or).			
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
ted ansit	ដ	events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	/Medical	UNPENDED AMENDED			
3760, ficate be g physici	e l	IF FEMALE: 23c. If yes, outcome of pregnancy	-	23d. Date of del	ivery
5876 ertificate ling phy	a	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	су	Month	Day Year
Box 68' e death certifithe attending cd for use as	sician	4 Pregnant at time of death 5 Other (Specify)			
D.O. Box 68 that the death certined by the attending detached for use as	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ires that the signed by	2	chronic alcoholism			Probably 4 V Unknown
ords, I	Completed		24a, Was a	n 24b. Wer	e autopsy findings available
Sor law re law be 2 sho		1	autops perform		r to completion of cause of th?
tal Rectian: The	5		1 ✓ Yes 2		Yes 2 No
certif	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing			
of Vital Records, ng Physician: The law requir then this certificate has been si meral director, page 2 should be	인	1 Yes 2 No		Residence 6 (Other:
Ision of Vital Rec	Certification:	1 V Natural 5 Pending (Month, Day, Year)	zou. Describe III	ow injury occorred	
Division tal or Attendi rs after death. al Director: /	<u> g</u>	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	treet and Number of	or Rural Route Number, City
Divi	<u></u>	3 Suicide 6 Could not be determined (Specify)	or Town, St		
Ilospital Hours 4 hours Funeral ely filled	-	29a. Certifier	due to the cause	e(s) and manner as	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial trans	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	the time, date a	ind place, and due	to the cause(s)
#3F8	≨¦	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
	\forall	O.C.M.E. OCN	TE .	July 8, 2008	
JK.Y.	1	30. Name and address of person who completed cause of death (Item 23a)			
- C		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201		
Sta	_	31. Date filed (Month, Day, Year) JUL 1 0 2008 32. Refistrar's Signature			
Registr	સા	JUL I U LOVO ANDRES (A			

		-	For State Registrar	nate of Ivial	iyiaiic		tificate of I		vicitai		J. No. 2	008	24111
Dhue	ioio		1. Decedent's Name (First, Middle, Last)		_				2. Date of Month		Day	Year	3. Time of Death
Phys /Me	dica		James D. Rosson, Jr	r.					July	1,	2008		10:00 P M
Exam	nine	r	4a. Facility Name (If not institution, give stre	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, or	Location of Deat	h			y of Death	-
			1007 Samantha Lane				Odenton	If Under 24 Hrs.		D: 11	Anne	Arund	
Funer Direct			5. Social Security Number 6. Sex 1払 M	2□ F 7. Age	(In yrs. 18 72	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	Hours Min.	(Month.	Day, 1	^(ear) 1935	9. Birthp Cour Virg	place (State or Foreign htry) inia
faryland show		ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
Mary a-f sh	3	202	Maryland Anne Aruno	ie1	0de1	nton							1 XYes 2 No
ith the or 28 e not		Director	10e. Street and Number	•			10f. Zip Code			10	g. Citizen of	What Cour	ntry?
ath w 23a ust b	3		1007 Samantha Lane V				21113			US			
at yial III A I A I S TOUGO should be filed within 72 hours after death with the Maryland and Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		/ runeral	1 ☐ Never Married 2X Married	Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give		0 - 13.	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	No-		ice - Americ ack, White, ifv:	
hours tural",	3	o o	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educati	Year or Dates:	197	7	lent's Usual Occup			1.	6b. Kind of E	Whi	
nin 72 In "na" Media	1	сотріете	(Specify only highest grade co		,—	(Give life. L	kind of work done of NOT use retired	during most of wo f)	rking	0.	ob. Killa of t	Jusiness/iii	uustry
d with giene graph that the latest the lates		Ę	Elementary/Secondary (0-12)	4	<u> </u>	Finan	ce Office	er		E	Army		
should be filed and Mental Hygi marked other matic event, t	3	oe Oe	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Mid	die, M	aiden Surna	ime)	
y I ould I Men narke	F	2	James D. Rosson, Sr			1.01.11.22		Anna Gil			0: T		
and 2 sho alth and N 27 is ma			19a. Informant's Name/Relationship (Type. Ruth Rosson/ Wife	Print)			g Address <i>(Street</i> Samantha				-		
C, Ivial yld s 1 and 2 should f Health and Mer item 27 is marke other traumatic			20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of	i	Date		0c. Location		
partification of permit. Pages 1 a Department of Hee Important: If item any Injury or othe			1X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	9	Maryla	natery or other place nd Cemetery	7/8	/2008	C	rownsv	ri 11 a	MD
permit. I Departm Importar any Inju	ej l		21. Signature of February entre Liver see		IVEL		. Name and Addre						al Home
B B B B	ouce.		2011			1	6000 Anna						
Physicia /Medic Examin	al		23a. Part1. Enter the disease, of complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)		u*i	c bil	er the mode of dyir			y arre	st,		Approximate Interval Between Onset and Death
rifficate be executed ag physician and as the burial-transit		al Examille	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a									
fficate g phys	15	Healical	d								-		
To the Hospital or Attending Physician: The law requires that the death certifinin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Al Cicion	FIIysiciari/IM	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	2 ☐ Fetal	death 3	Ectopic pregnanc Other (specify)	<i>y</i>		_		ate of deliv	rery Day Year
s that ned b	d	Dy FI	Part II. Other significant conditions contril	outing to death but	t not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. E	id tob	acco use co	ntribute to	the cause of death?
en sig	7		Prostate cancer	Valve	ila	hea	et di se	ase,	1	☐ Ye	s 2 No	3 ☐ Pro	bably 4 □Unknown
The law r te has be age 2 sh	100	completed	hypertension, ost fractures, glaucon	eoporos	sis	with	pathot	ogient	P	utopsy erform	24th	o. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
stan: prtifica ctor, p	0		25. Was case referred to edical examiner?					26. Place of De	1□ Ye eath <i>(Ch</i> eck or			1 🗆 163	20110
hysic this ce	F	0	1 ☐ Yes 2 ☐ No Hos	pital: 1 ☐ Inpatien			nt 3□ DOA Oth	er: 4 ☐ Nursing	Home 5 🕏 F	Reside	nce 6 □C	other (Spec	ify)
nding Physician: The lar ath. r: After this certificate has te funeral director, page 2	100		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		28b. Time o Injury	Wo	ryat rk? Yes 2 ∐ No	28d. Descri	ibe ho	w injury occ	urred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Cigital Co	Ceruncanon	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	ry - At ho . (Specify	me, farm, str /)	eet, factory, office		28f. Location City or	n (Str Town	eet and Nur , State)	mber or Ru	ral Route Number,
e Hospit 124 hours e Funera letely fille	le cip	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best or c: On the basis of and manner stat	examina ^a	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occ	ce, and due to curred at the ti	the ca	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)
To th within To th	1	M	29b. Signature and title of certifier	Λ	ı		29c. Licens	se number	-	29	d. Date sign	ned (Month	, Day, Year)
1			Manut. Mu	nonit	N	S	D41	2992			7/2	108	
AM		İ	30. Name and address of person who comp	oleted cause of de	ath (Item	23a) (Type,	Print)		mbri			•	
		- 1	TaraT. Muscorich		1 11 -	00 /	f	/	1	1/			1651

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 9 2008

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ye ar Physician OSCODAM FAN STINCHCOMB 07 500 B /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL 5. Social Security Number MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours Min. 213-28-153 79 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglene. anti-filed men 21s a marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is a marked other than "natural", or other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☑ No Director Anne Arundel Davidsonville MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21035 USA 734 Sharpsburg Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2√√√00
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 200No Specify: \$ Specify 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Riggins Bernard W. Sears ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 Sharpsburg Dr. Davidsonville, MD 21035 Carol Stinchcomb Daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 7/7/2008 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 21. Signature of Functal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Dalil 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONIA ONE WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Vear 5 Other (specify) P.0. the detached 9 Unknown بمعند nas been signed by ; page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ARTERY OCCLUSIVE 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Physician: The certificate 1 ☐Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Hospital or Attending 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 MEDICAL ANNAPOLIS 1 Stack PARKWAY, ('a Nm 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 12:35 AM MAXINE SNELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 560 LEWIS STREET HAVRE DE GRACE HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 XF 96 MAY 25, 1912 Director 248-28-7390 SOUTH CAROLINA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County show ed at 1 X Yes 2 □ No r 28a-f sh notified Director MARYLAND. HARFORD HAVRE DE GRACE the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code pe pe with 560 LEWIS STREET 21078 USA items 23a iner must b permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STERILIZATION TECHNICIAN HOSPTIAL 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRED MILLER MAGGIE EPPS ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RUBY L. SINGLETON / DAUGHTER 560 LEWIS STREET, HAVRE DE GRACE, MARYLAND 21078 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ST. JAMES UNITED CEM. 06/02/08 HAVRE DE GRACE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licenses MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eavs **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Box 68760 ettending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ Unknown 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s After this certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 27 No 1 Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Funeral Director: tely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours af er To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 24 one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of address of person who completed cause of death (Item 23a) (Type, Print) Robert Rapp Pulaski Highway, Suite 203 Houre De Grace, MO 21078 2027 Year) 31. Date filed (Month, Day, State MAY 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 9, 2008 **Physician** Albert Charles SALZBERG 2:55 P M /Medical 4a. Facility Name (If not institution, give street and number)
Suburban Hospital **Examiner** City, Town, or Location of Death Bethesda 4c. County of Death Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea June 27, 1 **Funeral** 10 M 20 F 116-30-1318 Director 1935 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with 20853 15201 Emory Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 white 1 ☐Yes 2 🕱 No Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "range any injury or other traumatic event, the Mextone. Elementary/Secondary (0-12) College (1-4or 5+) Education College Professor 18. Mother's Name (First, Middle, Maiden Surname)
Mary Bracci 17. Father's Name (First, Middle, Last) Be Victor Salzberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 15201 Emory Lane, Rockville, MD Helen Salzberg, Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 07/13/08 Olney, MD 21. Signature of Pun ral Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC <u> 20012</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 4 Days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Lissass or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burlal-transit that the death certificate be executed Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 Tyes 2 No. Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires Hypotension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No Respiratory Failure of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the Gasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Within 2 To the complex 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 9, 200829c. License number 20562

State

BER

Registrar
DHMH 17 Rev 1/2001

10215 Fernwood Road, Bethesda, MD

20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #405

3 Registrar's Signature

M.D.,

1 1 2008

Levin,

Barry J.

31. Date filed (Month, Day, Year)

JUL

			For State Registrar		State o	f Marylar		artmen rtificat		lealth and	Mental		ne .No. 20	08	24	118
	Physici	an	1. Decedent's Name (First, Ma	iddle, Last)							2. Date o	f Death		Year	3. Time of D	Death
	/Medi		Laura Mues					1			June	30,	2008		8:06P	M
	Examir	ner	4a. Facility Name (If not institute Suburban Hosp		street and nu	mber)		4b. City, Beth		r Location of Deat	h		4c. County		cv	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs	8. Date o	f Birth		9. Birthp	lace (State or	Foreign
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	the M	Director	DC 10e. Street and Number			Wa	shingt	on 10f. Zip	Code			100	. Citizen of W	hat Coun	A	
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Baltimore. Marvland 21215-0036	s 1 and 2 should be filed within of Health and Mental Hygiene, item 27 is marked other than other traumatic event, Item.		19a. Informant's Name/Relation Martin Schre				19b. Mailir	ng Address Milit	(Street	and Number or R	ural Route N 401 Wa	umber, C ashi	oity or Town,	State, Zip DC	Code) 20015	
٥	1 and Health tem 27		20a. Method of Disposition	JIIIC/ 110	abbana		Place of Dispo				Date		c. Location -		wn, State	
5	permit. Pages 1 Department of F Important: If ite any Injury or ot		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	State	cemetery, cier tional				/2008	F	alls C	hurcl	a. VA	
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			23a. Part 1. Enter the disease shock, or heart failure.	or complication	cations that o	aused the deat	h. Do not en	ter the mod	e of dyin	ng, such as cardia	c or respirate	ory arres	t,		Approximate Interval Betw	een
	Physician		Immediate Cause (Final disease or condition	a	INT	PACER	EBENT			ACCOUNT					Onset and De	eatn
	/Medical Examiner	Ш	resulting in death)			(or as a conseq	uence of):			Sell Di	- ar					
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자 Sisisi	r Atte	tific		ald not be ermined	28e. Płace buildi	of Injury - At he	ome, farm, str	eet, factory,	office		28f. Locati City o	on (Stre	et and Numb State)	er or Rura	al Route Numb	ber,
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	(10)		ZACHARY LEVIL	/EM	D 49.	27 AUS	VEN A	Vc Ber	HOSD	X MD 2	0814					
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7,^{Day}008 **Physician** July 2:40p Louise Blanche Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4/30/1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days West VA. 1 M 2 F 216-12-0209 Director 92 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 1 ☐ Yes ŽŽNo Director MD Anne Arundel Crofton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2402 Falbrook Lane 21114 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes **X**X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify. \$ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Exxon Mobil Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia C. Fox George M. Riley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Smith Jr. 2402 Falbrook Lane Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition IXXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet Cemetery 7/11/2008 Crownsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Septice Licensee 12 Ridgely Ave. Hardesty Funeral Home P.A. Annapolis. MD 21401 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Meumoin Examiner Due to (or as a consequence of) signed by the attending physician and a betached for use as the burial-transit UT1 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical Dementio IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy perform ospital or Attending Physician: Thours after death.
uneral Director: After this certificate ity filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50290 7-9-08 Shal MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20608 Fring MD Fred 110, HOSP Shal DhiRen 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1 0 2008 Registrar

Richard Bruce Stew	1- For State	State of Maryland	l / Department of Certificate of		d Mental Hy		_{1. No.} 20	08 2412
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First	t, Middle,Last) Richard Bruc	e Stewart			2. Date of Death	Day Year	3. Time of Death 0825 hrs
(4a. Facility Name (if not in	nstitution, give street and number Beach Farm Road		4b. City, Town, or Annapolis	Location of Death		4c. County of Dea	
Funeral Director	5. Social Security Number 228–66–9684	6. Sex 7. A	Age (In yrs. last birthday) Yrs	If Under 1 Yea Months Day		8. Date of Birth	(MM/DD/YYYY) 9. B Fore	sirthplace (State or sign Wash . DC
any	Usual Residence of Deceded 10a. State 10b. C	County	10c. City, Town or Local	tion				10d. Inside City Limits
ryland a-f show t once.	Maryland Ann	ne Arundel	Arnold	10f. Zip Code		10	g. Citizen of What Co	1 Yes 2 X No
th the Maryland 33a or 28a-f she poiffed at once	1026 Bayber			21012			USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Manital Status 1 Never Married 2	1 Yes		Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto		White, etc.	
hours afte natural", Sxaminer ed by	45 Decedent's Education	Divorced or Dates: on (Specify only highest grade c	during n		o specrry: ation (Give kind of we. DO NOT use retire		16b. Kind of Busines	
5-0036 led within 72 hour Hygiene. lother than "natu the Medical Exar Completed	Elementary/Secondary	2		employed				Electronics
21215-0 21215-0 und be filed v Mental Hygi marked oth ic event, the I	17. Father's Name (First, Chandler St 19a. Informant's Name/Re	•			18.Mother's Name Anna Lo	uise Roa	ach	
MD 21 d 2 should d 2 should tht and Me n 27 is ma numatic cv		elationship (Type, Print) Shacka/Sister					nber, City or Town, Sta apolis, Mo	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F	20a. Method of Dispositio 1 X Burial 2 Cre 4 Domation 5 0	emation 3 Removal from	State 20b. Place of Dispo crematory or o Mt. Comfc	ther place)		Date 4/2008	20c. Location - City Alexandri	or Town, State a, Virginia
Balti permit. Departu Importa	21. Signature of Funeral S		22. 29	Name and Address	ss of Facility Geo nons Islan	orge P. nd Rd. H	Kalas Fun Edgewater,	eral Home Md.21037
Physician /Medical	23a. Pal I. Enter the dise failure. List only one Immediate Cause (Final of	1-4		the mode of dying	g, such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
€ Examiner	or condition resulting in d	Due to (or as a co						
ted nsit Examiner	if any, leading to immedia	ate Due to (or as a co						
cuted and transit			nsequence of):					
60, ate be executed hysician and te burial - transit Medical Exa	UNPENDED IF FEMALE:	AMENDED 23c. If yes, out	come of pregnancy				23d. Date of deli	very
). Box 6876(the death certificate the attending physician for use as the b Physician/Me	23b. Was decedent pregn past 12 months?	4 Pregnan	t at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	Month	Day Year
ires that the de signed by the labe detached for by Phy		t conditions contributing to de	eath but not resulting in the	underlying cause	e given in Part I.			e to the cause of death? Probably 4 Unknown
Cords law requents been table to has been to should						24a. Was autop perfo	psy prior prmed? deati	
ital Recitions: The scertificate irector, page	25. Was case referred to examiner?	Hospital:	atient 2 ER/Outpatie		ce of Death (Check	only one)	Residence 6 🗸 0	
on of Vii nding Physi nth. r: After this re funeral dio	27 Manner of Death	28a. Date of FOUND:	Injury 28b. Time of FOUND:	f Injury 28c. In	jury at Work? Yes 2 ✓ No		how injury occurred	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the funeral Medical Certification:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined Coperify	of Injury - At home, farm, str	eet, factory, office	e building, etc.	or Town.		r Rural Route Number, City ad, Annapolis, MD
To the Hospi within 24 hou To the Funer completely fi		ifying Physician: To the best of ical Examiner:On the basis of	examination and/or investig	curred at the time, gation, in my opini	date and place, and on, death occurred	d due to the cau at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To with To com	29b. Signature and title o	and manner state	l i	1	nse number		29d. Date signed July 8, 2008	(Month, Day, Year)
	30. Name and address of Tasha Greenbel	of person who completed cause arg MD. Assistant Med		1 Penn Stree	t, Baltimore, M	D 21201		
State Registra	31. Date filed (Month, Da		strar's Signature	6. 4.				
DHMH 17 Rev 1/2001		LITTER I	ORIGIN	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death 03 VICTOR 07 5:40 AM 01 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death ANNE ABUNDEL ANNE ARUNDEL ANNAPOLIS MEDICAL CENTER | If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 31, 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1X M 2□ F 220-70-7126 51 1957 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Stevensville Maryland Queen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Tower Drive USA 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use relired)
Emergency Management Fire
Life Safety Officer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WMATA Public Transportation Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Size Geraldine Victoria Sauve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Tower Drive Stevensville, MD 21666 Laurie Sue Size/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Memorial Gardens 7/7/2008 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 alla In rel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHAGEAL CANCER MENTHS METASTATIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pendina investigation 1 Tes 2 No 2 Accident 6 Could not be

Examiner ed by the attending physicien end detached for use as the burial-transit death certificate be executed Division of Vital Records, P.O. Box 68760 99 cate has been significant category. After this certification, efter death. Director: Aft within 24 hours efter To the Funerel Dire

Physician

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Examiner

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Pages traint of the permit. Pages Depertment of Important: If it any Injury or c

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Examiner

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Certification: To

Director

Funeral

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Completed

with the Maryland

Baltimore, Maryland 21215-0036

Medical State

30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

3 ☐ Suicide

29a. Certifier

4 Homicide

THE WAR

MP, Zeol MEDICAL PKWY,

Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

ANNAPOLIS MD

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08

TIM CAPSTACK 31. Date liled (Month, Day, Year)

JUL 0 9 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c License number

D66753

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month <u>11:30</u> a [™] July 9, 2008 Max Safrin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCt. 13, 1904 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number Hours ^{Cou}Russia Days 103 266-71-2227 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Rockville 1 ☐ Yes 2 ☐ No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20852 #2194 6105 Montrose Rd., 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tsivia Frank Aaron Safrin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 506 Hermleigh Rd. Silver Spring, MD 20902 Reina Lerner/ Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 11, 2008_ Adelphi, MD Mt. Lebanon Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home ons that caused the death. Do not enter the mode of dying, su ause on each line. St., NW Washington, DC 20012 ch as cardiac or respiratory arrest. 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) vancelage Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 2 🙀 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA

Physician /Medical Examiner

attending physician and for use as the burial-tran

cate has been signed by page 2 should be detach

certificate

After this

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within 24 hours after To the Funeral Dire Hospital

or Attending Physician:

Completed by

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Medical Certification:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

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Completed by Funeral

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the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If fleen 27 is marked other than "never any Injury or other traumatic entering the process.

Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No 27. Manner of Death 1. Natural 5 ☐ Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

6 ☐ Could not be determined

0036716

29d. Date signed (Month, Day, Year) July 9, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Rd., Rockville, MD 20852 M.D. Kundrat Andrew G. 31. Date filed (Month, Day, Year)

State Registrar

11 2008 JUL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year JULY 9, 2008 **Physician** 6:57 AM CLARICE MARCELLA TOLSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES 1711 DANIA DRIVE FORT WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) JAN. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F MARYLAND 82 1926 Director 578-38-7544 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show diral Examiner must be notified at 1 X Yes 2 □ No Director PRINCE GEORGES FORT WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 20744 UNITED STATES 12320 LIVINGSTON ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1X Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify: Completed by BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) ASST. DIRECTOR OF PERSONNEL D.C. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERTA TOLSON PERCY TOLSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 DANIA DRIVE, FORT WASHINGTON, MD 20744 SHERRIE WALKER/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY JULY16,2008 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee
LYDIA C. THORNTON JOHNSON THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death eno Caranoma Ot Metas Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 1□ Yes Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NIECES HOME 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Registrar

31. Date filed (Month, Day, Year) JUL 1 4

29b. Signature and title of certifier

29a. Certifier

(Check only

DICOULCINO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + LL 12D, 507, Oxou HTLL, MD 20748
SMLV 63766 OLCONICWO 6692 OXOU HTLL 12D, 507, Oxou HTLL, MD 20748 32. Registrar's Signature

1 💇 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0055314

29d. Date signed (Month, Day, Year)

07-11-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 635 AM Month Year **Physician** OWSV 8005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1313 McKinley St. Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Apr 2 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Virginia Days 1XM 2□F 68 Yrs 1940 228-46-5286 Apr Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 10b. County 1XYes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 1313 McKinley St. 21403 USA 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner: Armed Polices:
1 Types 2 No
If Yes, Give
Year or Dates: 1959-61 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Electrician Nava1 Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Banks Rosa Taylor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Taylor(Wife) 1313 McKinley St. Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-7-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windows & AciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee Jarry & Here Mac 483 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Own. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1☐ Yes 2☐ No death? 1 ☐ Yes 2EN0 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) To the l within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State JUL 0 9 2008

30. Name and address / per

on who completed cause

death (Item 23a) (Type, Print)

Registrar

			State of Maryland	/ Depa		lealth and	Mental Hy	_	
	6		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Sarah E. Thomas				July	3 2008	1527 м
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	4c. County of De	
-0			Anne Arundel Medical Center		Annap		T = 5 :	(rundel
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. las 76	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da ACL 15	y Year) 9. B 5 1932 Ma	Birthplace (State or Foreign Country) Aryland
	and t		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	own or Lo	ocation				10d. Inside City Limits
	Mary f sho	ō	Maryland Anne Arundel An	napo	lis				Yos 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code			10g. Citizen of What 0	Country?
	h witi	a	1902 C Copeland St.		21	401		USA	
	ems ems	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14. Race - Ar Black, Wh	merican Indian,
036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jigal Exphirer must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	1 □Yes 🎾 No	Specify:	o riioan, cic.,	Specify: E	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	I6a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo d)	rking	16b. Kind of Busines	ss/Industry
21	d wit	Son	6th 0		Cook			Beverly	Beach
pu	oe file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Surname)	
<u>ya</u>	Men Men arke	ျှ	Joseph J. Creek			Mary W	ilson		
Maryland	2 sh h and rism raum				•			er, City or Town, State	
e,	1 and Healt em 27 ther t						. Croff	ton, Md.	
ρ	ages nt of : If it				osition (Name of matory or other place				
Baltimore,	artme ortant injury		4 □ Donation 5 □ Other (Specify) Ma.1 21. Signature of Funeral Service Licensee		d Veter			Crownsvi uary, P.A	
Ba	Department of the second of th		Jarry 1, Seen MED 483	8	21 West	St. An	napoli	e, Md. 21	
	hysician /Medical Examiner		23a. *art 1. Enter he disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	10	n Ch	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
760,	The law requires that the obtain betting the executed attending bhysician and bage 2 should be detached for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen						
Box 68	tending phy	Physician/Medi	IF FEMALE: 23b. Was decedent pregrant in the part 13 modes? 1 □ Live birth 2 □ Fetal de		☐ Ectopic pregnanc	W.		23d. Date of	
P.O. E	signed by the at be detached fo	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year
rds, F	w requires that should be defined about the definition of the defi	ρ	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did t		e to the cause of death? Probably 4 Unknown
l Records,	cate has bei	Completed		-			24a. Was auto perfo 1 ∐ Yes	psy prior death	autopsy findings available to completion of cause of 1?
Vital	is certificate director, pag	Be	25. Was case referred to medical examiner?		-	26. Place of De	ath (Check only o		
of Vita	양양	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF	/Outpatie	nt 3 DOA Oth	4 Li Nursing I	fome 5 ☐ Resi	dence 6 Other (S	pecify)
	Affe	ë.	1 Natural 5 ☐ Pending (Month, Day, Year)	Bb. Time of Injury	Worl		28d. Describe	how injury occurred	
Division	e is at	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, st		Yes 2 □ No		Street and Number or wn, State)	Rural Route Number,
iO Tolerand	within 24 hours after de To the Funeral Direct completely filled in by th		29a. Certifier (Check only Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination	edge, dear	th occurred at the timestigation, in my control	me, date and place	e, and due to the	cause(s) and manner	r as stated. due to the cause(s)
4	within 2 To the complet	Medical	one) and manner stated. 29b. Signature and title of celtifles.		20a Linene	o mumber		29d. Date signed (Mo	anth Day Yarr
٩	8 4 8	5	29b. Signature and title of celtifier \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nc) 29c. Licens	8446		07/03	3/208
	A CONTRACTOR		30. Name and address of person who completed cause of death (Item 2:	JC.	Print) NJ-L	AVE	Don	upolis 1	40
	Sta Registra		31. Ďate filed (Month, Day, Year) JUL 0 9 2008	· Second	de 1			,	

State Registrar DHMH 17 Rev 1/2001 08-05524 Richard Alan Volin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24126

VICITO	ilu Alan Vo		1-For State Control of Peattre and Mental Peattre Certificate of Death	Reg.	No.	
	Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	ay Year	3. Time of Death
Medi ⁄	ical Exam		RICHAID VOIII	July 19, 200	8	0030 hrs
			4a. Facility Name (if not institution, give street and number) Montgomery General Hospital 4b. City, Town, or Location of Dea Olney	th	4c. County of Death Montgomery	
	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	rs. 8. Date of Birth (MM/DD/YYYY) 9. Bir	thplace (State or
	Funeral Director		216-92-8377		, 1964 Foreign	Washington D.C.
	any ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1	*	_	MD Montgomery Rockville			1 X Yes 2 No
1	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
U	the N a or 2	Dir	14008 Bauer Drive 20853		U.S.A.	
7	MOre, MID 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygiers, and the Heath and Mental Hygiers with the mit. If item 27 is marked other than "natural", or items 23a or 28a-f sho mit. If item 27 is marked other than "natural", or items 23a or 28a-f sho not it item 27 is marked other than "natural", or items 23a or 28a-f sho not item 25a or 26a-f sho	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (15. Was Decedent of Hispanic Origin? (16. Yes, specify Cuban, Mexican, Puer		14. Race - Amer White, etc.	ican Indian, Black,
	ter de ", or i	Fu.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Whi	te
~	ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the completed)		6b. Kind of Business/	Industry
	5 72 hc m "ns ral Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re	etired)		
	5-0036 led within 7 tygiène. other than	Completed	12 Never Worked		None	
į	21215-0036 Auld be filed within 7 Mental Hygiène. marked other than c event, the Medica			me (First, Middle, Ma	,	
3	D 2121; hould be fill nd Mental I is marked ttic event,	To Be	Rudo1ph Volin Ann Rut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Ann Rut)	th Schrie	The state of the s	e, Zip Code)
	MD id 2 shot allth and m 27 is aumatic	1	Rudolph Volin - Father 14008 Bauer Drive Ro	ockville,	MD 20853	
	ore, ML ss 1 and 2 s of Health ar If item 27 her trauma	l	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City o	r Town, State
	more, MD Pages 1 and 2 sho ent of Health and nt: If item 27 is		1 X Dullar 2 Cremation 3 Removal non-state	/21/2008	Rockville	, Maryland
:	Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr		21. Signature of Fuerral Service Licensee 22. Name and Address of Facility Edward Sagel Funer			
(a ₽9 ₽:€	n e	1091 Rockville Pik	ce Rockvi	lle, MD 20	0852
	Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
.	xaminer	8	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hypertrophy	eft ventri	icular	Death
			530 to (at 25 0 0 10 0 0 0 1)			
		盲	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			7
P	uted Id ransit	Ë	d.			
	e exec sian an ial - tr	lical	X UNPENDED AMENDED 23a,27,28a-f, perME, g882 8/2	22/08 TT		
	760, cate be executed physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	
Ġ	BOX 687 E death certific the attending p ed for use as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	Month	Day Year
	SOX death e atte	ysic	1 Yes 2 No 9 Unknown g Unknown			
	O, E at the 1 by th tached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
(res that signed be de	d by		1 Yes	2 No 3 Pr	obably 4 🗸 Unknown
-	rds requi	Completed		24a. Was ar autops	and the second second	autopsy findings available completion of cause of
	eco he law ate has	티티		perform 1 ✓ Yes 2	ned? death?	
	T. T. T. Striffice tor, pe		25. Was case referred to medical 26.Place of Death (Che			
3	DIVISION Of VITAI RECORDS, P.O. tal or Attending Physician: The law requires that the rate death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	To Be	examiner? 1 • Yes 2 No	rsing Home 5 F	Residence 6 Oth	er:
•	After Unera		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	1 -	ow injury occurred	
	ttend ttend death. ctor:	Certification:	Pending Investigation Fnd 7/18/08 Fnd 11:50 Pm Yes 2 X No	unk		
•	I or A after U Dire	≝	3 Suicide 6X Could not be determined (Specify) Subject found in house	28f. Location (Story Town, St	ate) 4306 Par	Rural Route Number, City
	DIVISION Hospital or Attend 24 hours after death, Funeral Director: etely filled in by the		4 Homicide	Rockvil		ated
	DIVISION Of VITAL RECORDS, P.O. BOX 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred to the control of			
_	To To Con	Mec.	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
			O.C.M.E.	OCME	July 19, 2008	
			30. Name and address of person who complete cause of death (Item 23a)			
		96 A	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 21201		
		tate				
	Regis	trar	JUL 2 2 2008 Mayor to from			

State of Maryland / Department of Health and Mental Hygiene 008 24127 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jackson Ward 8:43 A M Andrew July 9, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, June 28, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours XXXX 2 F Yrs 80 173-20-6198 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show the Medical Examiner must be notified at 1 Tyes 2XXNo Maryland Prince George's Director Glenarden 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3643 Cousins Drive 20774 TISA items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? NXIYes 2 □ No 1946-If Yes, Give Year or Dates: 49 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Computer Programer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental h **Israel** Ward Mattie Armstead ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3643 Cousins Dr., Glenarden, MD 20774 item 27 l Ethel Ward - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any njury or ot once Nation 3 ☐ Removal from State Maryland Vet. Cemetery 07/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Lipersee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Laknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient မှ 2 ER/Outpatient 3 DOA After this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1xx Natural within 24 hours effer death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel Cartifying Physician: To the best of my knowledge, death deserted at the time, date and place, and due to the cause(s) and manner as stated.

2 Modest Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23s Certifier Medical tle of certifier. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 1 n of death (Item 23a) (Type, Print) Arastog Yazdani State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1ADDLAU **Physician** Tuly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Vantage House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Days Months Hours 1 □ M 2 🔀 F Director June 5, 1926 Michigan 080-36-5787 82 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 □Yes 2 X No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21044 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: à 3 Nidowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) New York State 5+ Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental P Important: If Item 27 is marked ot any injury or other traumatic ever Be and 2 should be Milledge Mack Bessie Matthews P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcile J. Wardlaw - Daughter 1274 State Route 31, Lebanon, New Jersey 08833 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 07/14/2008 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 ☐ Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Hinknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an ate has page 2 s autonsy perform 1□ Yes 2 210 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 1 2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July, 10 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL, SUITE Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician July 8, 2008 3:55 p Mindel W. Wolfe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House
5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Year) Days 1 □ M 2 √F 1926 Washington, DC 82 267-30-0867 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, It a Modical Examination must be notified at 1√1Yes 2 No Director Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 11410 Strand Drive # 401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 DNo If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify: ò 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental ပ Earl Palmer Warfield <u>Helena Greenstein</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra once. 11410 Strand Drive, # 401, Rockville, MD 20852 Sidney Wolfe-Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial 7/11/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Simple Tribute Syn 1040 Rockville Pike, Roackville, MD 20852 1 Jusch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple Myeloma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical the as i attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 □Yes 2 X No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 Hospital or Attending uspital c. 24 hours after de... "eral Director: An in 24 hours • Funeral Discoving Services completely within 2.

3altimore, Maryland 21215-0036

State Registra

31. Date filed (Month, Day, Year) JUL

11

2008

29b. Signature and title of certifier

29a, Certifier

(Check on

Genevieve Wroblewski, MD, 1355 Piccard Drive, Suite 100, Rockville, MD 20850 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



**X*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0064615

29d. Date signed (Month, Day, Year)

July 9, 2008

amend lines 8 08-05130 8 John Michael W	and	l 19a per fd aaco l Please Ty	pe of Frint it	PB/98kiliw	delible	ink. Ensur	e All Cop	oies Are Le	egible.		
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Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Mid John Michael						2. Date of De Month July 4, 2	eath Day	Year	3. Time of Death 0924 hrs
Jun .		4a. Facility Name (if not institut . 12703 Millstream Dri	ion, give street and n	umber)		4b. City, Town, o	r Location of De	eath		ounty of Deat nce Georg	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la	• /	If Under 1 Yes		Hrs. 8. Date of i	er 9, 19	982 Forei	rthplace (State or gn
	-	23.0-29-1375 Usual Residence of Decedent	1 XM 2 F	25		rs.		Sept.	10,	1982 C	ountry) Virginia
id how any	_	10a. State 10b. County Maryland Pri	y nce George		Town or Loc ie	ation					10d. Inside City Limits 1 X Yes 2 No
5-0036 Hed within 72 hours after death with the Maryland other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code			_	n of What Co	untry?
ith the 23s o notiff		12703 Millstr 11. Marital Status		cedent Ever in U.	S 13 W	20715 Vas Decedent of H	ispanic Origin?	/ Specify Yes or	USA No- 114	1. Race - Ame	rican Indian, Black,
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tox 68760, eath certificate be execute attending physician and for use as the burial - tran	Physician/Medica	past 12 months?	4 Pres	gnant at time of de	eath 5	Other (Specify)					
D. B t the de by the		Part II. Other significant con			esulting in th	ne underlying cause	e given in Part I	. 23e. D	id tobacco u	se contribute	to the cause of death?
ires that signed	d by						-			No 3 P	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi								_ _ p	utopsy erformed?	prior t death	
of Vital Reco ing Physician: The law After this certificate has uneral director, page 2 s	ပြီ	25. Was case referred to med	ical			26.Pla	ice of Death (Ch		es 2 No	1 🗸	Yes 2 No
Vita vysician this cer direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpati	ent 3 DOA	Other ₄ N	lursing Home 5		nce 6 🗸 Ot	her: Scene
Sion of Attending Phrdeath.		27. Manner of Death	28a. Da Jul ^{(Mo}	te of Injury hth Day,Year) 2008	28b. Time 0900 hrs		njury at Work? Yes 2 ✔ No	Subject 9	ibe how inju shot self	ry occurred	
ivisio or Atten after death Director:	Certification:	2 Accident In 3 Suicide 6 C	vestigation ould not be 28e. Pl	ace of Injury - At h	nome, farm, s	treet, factory, office	e building, etc.	28f. Location	on (Street ar	nd Number or	Rural Route Number, City
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To the Hosp within 24 hc To the Fun- completely?	Medical	(Check only one) 2 Medical E	xaminer:On the basi and manne	s of examination a	and/or invest	igation, in my opini	on, death occur	rred at the time, o	date and pla	ce, and due to	the cause(s)
F 3 F 8	Me	29b. Signature and title of cer		7			ense number C.M.E.			Date signed (Month, Day, Year)
W.	7	30. Name and address of pers						0.105			
He		Laron Locke MD. 31. Date filed (Month, Day, Ye.	Assistant Medic	cal Examiner Registrar's Signat		enn Street, Bal	timore, MD	21201			
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Á	Physici /Medic	_	Chris	1 1	hin	gton		Month July	Day 3	Year 2008	
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location					10d. Inside City Limits
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	a or 28	I Dire	10e. Street and Number 204	7 Parker Dr.		10f. Zip Code	101		10g. Citize	n of What Cot	untry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	.S. 13	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		Race - Amer Black, White pecify:	
3altimore, Maryland 21215-0036	72 hour 'natural dical Ex	eted b	15. Decedent's E (Specify only highest gi	Year or Dates: Education rade completed)	i (Gi	cedent's Usual Occup ve kind of work done	during most of wor	rking	16b. Kind	of Business/I	ndustry
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	who !)	1 Wines	Imen ()	m	0. 18	3966		Juli	1, 3,	2008
4	D/QX		30. Name and address of person who	o completed cause of death (Iter	m 23a) (Typ	Baltin	V0V0	Mp	213	DI	AA SMATI
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			ertificate of De	eath	Reg. No. 2008				
Physi /Me		lillia M. Uhalan		2. Date of Do Month July	Day Year	3. Time of Death 9:29 am			
Exam			4b. City, Town, or Loc Bowie	cation of Death	4c. County of Death				
Funera Directo		5. Social Security Number 5. Social Security Number 6. Sex 1 □ M 2 F 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 86 Yrs.		Under 24 Hrs. 8. Date of Bi Hours Min. (Month, D. Feb. 1	rth ay, Year) 9. Birth Co. 0, 1922 Wash	nplace (State or Foreign intry) ington, DC			
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ith the M or 28a-f	Fineral Director	Maryland Prince George's Bowie 10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou				
death w ems 23a er must l	neral	13107 Oval Lane	20715 Was Decedent of Hispa	nic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)	USA 14. Race - Amer				
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120	Y	Nader Tavakoli, M.D. 4000 Mitchellvi		ite A-312 Row	ie. MD 20716				
S Regis	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Land a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JARE /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death rundel NNAPOlis 105 p If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Sex XX M 2□F Months Days Hours Min. Director 546-66-2254 June 18 1946 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exacitivit coust by notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö than "natural", or items 23a 1350 Tanook Court 21409 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. † Ves 2 No 1966− HYes, Give 1988 Year or Dates: 1988 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 □ Yes 🏚 No Specify. 3 Widowed 4 Noivorced White 1988 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lieutenant Colonel U.S. Marines Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi Frank Dochnal Anna Tiemann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trace Elizabeth Ware / Daughter 1350 Tanook Court Annapolis, Maryland 21409 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/9/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home. Inc. mill a 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CArdIA /Medical resulting in death) Due to (or as a consequence Examiner erioscleratie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician the burial P.O. Box 68760 Physician/Medical use es IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Division of Vital 1 □Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 KER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death Director: death the 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29b. Signature and title of certifier EPUTY 29d. Date sigged (Month, Day, Year) Name and address of person who completed ruse of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Date filed (Month, Day,

Year.

JUL 0 9 2008

distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 7-25-2008 **Physician** 3:53A Joan Amato /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto. Parkville Morningside Asst. Living Birthplace (State or Foreign Country)
 Iowa If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 8-29-1931 Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 76 Director 474-32-4609 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examinar mat bu nutlined at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Harford. BelAir Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 120 West Broadway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry J. Theder Nellie Dring ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 West Broadway BelAir, Md. 21014 John Amato III 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-28-2008 BALTO. Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funer Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disease **Physician** yeur Zheimer's disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after cleath.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

利性 28

32. Reg

NYSIEIGH

29c. License number

D26534

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Maryland / D	•	of Health and Ne of Death	fental Hygie	711118	24135		
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	LLEN			2. Date of Death	Day Year 2008	3. Time of Death		
	Examir		4a. Facility Name (If not institution, give str JOHNS HOPKINS HOS 5. Social Security Number 6. Sex		ВА	Town, or Location of Death LTIMORE 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death	nplace (State or Foreign		
	Funeral Director		224-46-7550 Usual Residence of Decedent	a 2□F 67	Yrs. Months	Days Hours Min.	(Month, Day, Ye DEC 22 1	ear) Co	GINIA		
	he Maryiar 8e-f show	Director	10a. State 10b. County MARYLAND N/A	10c. City, Town	LTIMORE		10-	Cisi- an ad 18th an Ca	10d. Inside City Limits 12 Yes 2 □ No		
	within 72 hours after death with the Maryland ane. than "natural; or Items 23a or 28e-f show the Medical Examinal; ust be invitited at		10e. Street and Number 1705 E EAGER STR 11. Marital Status 12	. Was Decedent Ever in U.S.	10f. Zip	21205 ent of Hispanic Origin? (Sprify Cuban, Mexican, Puerto		U.S.A. 14. Race - Ame	rican Indian,		
9000	nours after o iral', or Iter	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, spec				ACK		
21215-0036	i within 72 h iene. r than "natu the Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) unknown	completed) College (1-4or 5+)	Decedent's Usua (Give kind of wor life. DO NOT us INTANCE	k done during most of work	king	o.Kind of Business/ HOUSING A F BALTIMO	UTHORITY		
yland 2	2 should be filed v n and Mental Hygie is marked other t raumatic event, III	To Be C	17. Father's Name (First, Middle, Last) THOMAS ALLEN				e (First, Middle, Mai				
Baltimore, Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryian it of Health and Menial Hygene. If Itam 27 is marked other than "natural; or Items 23s or 28e-f show or other traumatic event, the Wedical Examinal with the Italian Allied at		19a. Informant's Name/Relationship (Type Betty L. Walker/Cou 20a. Method of Disposition	sin 17	05 E. Ea	(Street and Number or Ru. ger St. Art le of	101, Balt	0.952	21205		
altimor	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trai		XXBurial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	WESTE	RN STAR 22. Name and	07-2			E, MARYLAND		
Ø	Per Per Per Per Per Per Per Per Per Per		232 Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do recause on each line.	1206 W not enter the mode		or respiratory arrest		Approximate Interval Between Onset and Death		
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	ELEC on: ON SION	ACTIVI	14	1DAY 25 MENTER			
8760,	tate be executed shysician and the burial-transit	ed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
	The law requires that the death certificate als been signed by the attending phy page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pre			23d. Date of del Month	ivery Day Year		
	w requires that been signed b should be deta		Part II. Other significant conditions control HYPERTEN	ibuting to death but not resulting in	n the underlying ca	ause given in Part I.	23e. Did tobac		the cause of death?		
Vital Records,		Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of 2 No		
of Vita	Phys r this ral dii	Certification: To Be C	To Be	To Be	25. Was case referred to medical examinar? 1 Ves 2 No 27. Mann of Death 1 Natural 5 Pending			A Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how		cify)
Division of	for Attan after deat Director:		2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	m, street, factory	1 ☐ Yes 2 ☐ No , office	28f. Location (Stree City or Town, S	at and Number or Ri State)	ural Route Number,		
	To the Hospital or Attantwithin 24 hours after deatl To the Funeral Director:	Medical C	(Check only 2 Medical Examine one)	cian: To the best of my knowledge r: On the basis of examination an and manner stated.	d/or investigation,	in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)		
	To T com	Σ	29b. Signature and title of certifier	aglorno		License number	0 3	Date signed (Mont	4,2008		
4			30. Name and address of person who com A 31. Date filed (Month, Dall Year) 2 2	4 LOR 2000	(Type, Print)	KERST	BALTO.	1402	1202		
	Sta Registr		305% 02	32. Registrar's Signature	Result	P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 255 PM July 2008 4c. County of Death 4b. City 4a. Facility Name (If not institution, give street and number) Town, or Location of Death South Rosedale Street Baltimore NIA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11-25-44 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 M 2 □ F Months Days Hours Min SOUTH CAROLINA 216-42-3573 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10h County ALTIMORE 1 XYes 2 □ No MARYLAND 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ROSET 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Black, White, etc 1 X Never Married 2 ☐ Married Sept. 18, 1962 Aug. 9, 1975 Specify: TBLACK 1 ☐Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WORKER TELEPHONE INSTALLATION CO. Elementary/Secondary (0-12) College (1-4or 5+) YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) QUINCY MAF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTER) BALTIMORE, MD 21229 JANET V. ADAMS JENKINS 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARRISON FOREST CEM 07-30-2008 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 North F-U Hon Avenue MD 21. Signature of Funeral Service Life Joseph H. Brown Jr. Funeral Home Baltimore Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNG disease or condition resulting in death) Due to (or as a consequence of): CARCINOMA OF GLOTTIS 5 QUAMOUS CELL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2UNo 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

be executed

requires that the death certificate

certificate

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Division Hospital or Attending **Physician**

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other traumatic event, the Medical Exanting must be notified at

21215-0036

Maryland

Examiner Physician/Medical

physician and s the burial-trans attending p for use as t signed by the a Completed by icate has been siç page 2 should b After this certific funeral director, Be Certification: To

IF FEMALE 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

Medical

1 Natural
2 □ Accident

3 Suicide

4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed call e of death (Item 23a) (Type, Print)

NATHERINE STAROPOLI 10 NORTH CREENE STREET, BALTIMORE, MA Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Alfred John Bandurski 2008 8:25 July 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick if Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number Age (In yrs. last birthday, 9. Birthplace (State or Foreign Pennsy Lvania **Funeral** XXM 2□ F 196-18-9950 Director 84 June 20, 1924 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location iral", or Items 23a or 28a-f show Extrainer must be notified at 1 ☐ Yes 2 No Funeral Director MD Howard Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 16830 Frederick Rd. United States 12. Was Decedent Ever in U.S. Armoed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 AMarried Maryland 21215-0036 1 □ Yes XXNo Specify: White Completed by 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "naturury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Plant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bandurski Julia Kranicki ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen R. Stoner(Daughter) 16830 Frederick Rd Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If iter any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Highland Mem. Park 7/31/2008 Pottstown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Oueen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Licens a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIENOTIC CZREBANK VASCALAR OKENSE Physician MONTHS-4892S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ RECENT HERNIN REPAIR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed CIRRHOSIS OF THE LIVER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 7 - 25 - 0829c. License number 0 76499 29b. Signature and tile of of 30. Name and address of person who completed cause of death (Item a3a) (Type, Print)

Registrar

State

31. Date filen (Month, War Creat)

2 8 2008

ORIGINAL

Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1636 2008 Barber 7 Senova /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number, **Examiner** Baltimare Hayland Nedical Centr If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 ₹M 2 □ F Months Days Hours Director 03 01 MD 216-88-9955 63 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evan for ust be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 **X** es 2 □ No Funeral Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21201 1012 Pennsylvania Ave Apt 102 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 🐒 □ No Specify Specify: Completed by Black 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Barber Elementary/Secondary (0-12) College (1-4or 5+) 11th grade na Transportation Garage Supervisor 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Willie Mae Green Eli Willie Barber ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 6204 Falkirk Road, Baltimore, Md Bernadine Poole-Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/25/08 Baltimore, Md Zion 21. Signature of Funeral Service Licansee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemia deritoritis disease or condition resulting in death) /Medical Du to (or as a consequence of) Examiner Small Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, piraton IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate Yes 2 No Division of Vital Hospital or Attending Physiclan: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[7No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of Certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frighthead Street, Baltmore, MD 21201 22 5. and 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 8 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. APPN TIPE, 9, 2a-c, perith, 381, 1/28/08, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:01 PM 2008 Junius Herman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Veters Alfairs Medical Center Baltimore NIA Baltimore 8. Date of Birth 1/10/1925. Birthplace (State or Foreign (Month, Day, Year) Country VA. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 219-12-6058 Months Days 1XM 2□F 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 XYes 2 □ No Baltimore MD Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iges 1 and 2 should be filed within 72 hours after death with it of Health and Mental Hygene. It is the file and 28 and than "natural", or items 28 a or, or other traumatic event, the Medical Examiner must be re or other traumatic event, the Medical Examiner must be re-SA 21239 Varkway hinquapin . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2DNo Maryland 21215-0036 Black Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aborer Bethlehem 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ rober 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22Nd Street Baltimore, MD. 21218 Herman Bates 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o important: If any Injury or Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. Weatherfard Functal Structure 31 E. Oilverst. Bulto, MD. 21213 21. Signature of Funeral Service License 2431 E. Oliverst. Approximate Interval Between Onset and Death 23a. Part1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (// as a consequence of): +ailure teant /Medical Examiner Obstriction esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19000 24,2008 July Gratis MID 30. Name and addres n who impleted cause of death (Item 23a) (Type, Print) S. Greene St, Baltimore, MD Small ind 10 31. Date filed (Month, Day, Year)
JUL 2 8 2008 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Speak!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Barber 6:20PM **Physician** Joseph 22 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore Kandallstown - Northwest Hospice Jeasons Hospice Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, 0817 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours 1**X**M 2□ F 216.36.3507 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Evanting must be notified at Baltimore 1 Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Black Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Medical once. College (1-4or 5+) Elementary/Secondary (0-12) Waverly 12th arade 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Raymond Barber bsanna (urtis ပ 19a. Informant's Name/Relationship (Type. Print) Dung ner) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Offutt Road Randallstown 370 acquelyn B. Washinaton 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 28 08 Cathedral 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Naugha C. Greene Funeral Srvcs M Road Kandallstown MD 21133 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final opstruturpulmonon disease Physician onwork disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examine law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No Month Day 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ፩ 3 robably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) nospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

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ELYSE MICINEURY 7D Mains met Reistritum, 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUL 28

2008

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		State of Maryland / Department of Health and Mental Hygie 1 - State Registrar Certificate of Death Reg.							giene,	2008	24141		
			Registrar 1. Decedent's Name (First, Middle, Last)					Boatin	2. Date of De	eath		3. Time of Death	
	Physician Robert Kenneth Blaine							July 25 2008		2008	1:20 P M		
		Examiner 4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death			4c. County of Death		
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	leath v	erai	714 Park Road	12. Was D	ecedent	Ever in U.S.	13. \		Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or N		4. Race - Ameri	can Indian,
9	or Iter	, Fur	1 Never Married 2 □ N		Forces?	No	1	If Yes, specify Cub 1 □Yes 2 1 X No		Rican, etc.)		Black, White, Specify:	
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Maryland	should and Me mark umartic	욘	19a. Informant's Name/Relati				19b. Mailir	ng Address (Street	and Number or Ru			Town, State, Zi	p Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Evantment rust be notified at once.		4 □ Donation 5 □ Other			Ceda		1 Cemeter				land, M	aryland sda-Chevy
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		ertifica		uld not be ermined 28e. P	ace of In uilding, e	jury - At hom tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28f. Location City or 7	(Street an Town, State	nd Number or Ru e)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24142 State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 21 **Physician** 2008 KIMANNI DEMETRIA BRISCOE 10:15 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | 1 Min | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Year | 0 Month | Days | Weath | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Weath | Days | Birthplece (State or Foreign Country)
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any injury or oth 1 ☐ Burial 2X Cremation 3 ☐ Removal from State BALTIMORE CREMATORY 7/25/2008 BALTIMORE, MD 21229 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Segrice Licenses LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE ulle 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EXTREME PREME /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day į in the past 12 months? 1 ☐ Yes 24 No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 'performed' 1 Yes 2 🗆 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TM Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month/Day, Year) 29b. Signature and title of certifier 29c. License number D00555 KS 5010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN RD, SILVER SPRING MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

HOLY CROSS HOSPITAL, SILVER SPRING ,MD 02910

2008

32. egistrar's Signature

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	irtment of H tificate of L		ental Hygie	ene 3. No. 2008	3 24143	
	Physicia		1. Decedent's Name (First, Middle, Last) Dorothy R. Cos					2. Date of Death Month July	Death Day Year 23 2008 12:35P M		
्	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of Death			4c. County of Death		
			Dove House			Westminster				Carroll	
	Funeral Director		214-20-3438	7. Age	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/22/1	9. Bir 921	thplace (State or Foreign puntry) MD	
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mary Fied a	to	MD Carroll	L	Westmins	ter				1 □Yes XXNo	
	or 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
	23a cust b		105 South Center			2115			14.5	USA	
	er de litems	Funeral	TT, Maritar States	12. Was Decedent E Armed Forces?	Ever in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
38	ırs aft N'',or Xamii	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	10	1□Yes 2ᢂNo	Specify:		Specify: T	Black	
215-0036	d within 72 hours after death with the Maryland glene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at		15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual Occup	ation during most of work	ing 1	6b. Kind of Business	/Industry	
121	within intention in the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of work		Gould, Ir	20	
2	it it		17. Father's Name (First, Middle, Last)		Frect	ronics As	18. Mother's Name	e (First, Middle, M		10.	
au	be properties of the even	To Be	Albert Augustus	King			Carrie	Rachel T	homas		
Maryland	should be and Menta s marked umatic ev	۲	19a. Informant's Name/Relationship (Ty	' ' .		•			City or Town, State,	Zip Code)	
	1 and 2 Health a tem 27 Is		Patricia Hutchins	(Neice/I					NY 11213		
altımore,			20a. Method of Disposition 1★Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac		0/2008	20c. Location - City o		
≣	t. Pag rtmen rtant:		4 □ Donation 5 □ Other (Specify)		¢arrison F				Owings Mi		
g	permit. Pages Department of Important: If I any injury or o		21. Signature of Funeral Service Licens	ee					& Cremato infield, N		
H	-		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
	Physician	į i	Immediate Cause (Final disease or condition	TO GALLOS OTT GALGTT III	HS,	40				Onset and Death	
7	/Medical Examiner	Je.	resulting in death)	Due to (or as	a consequence of):						
	Laminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
7	uted I ansit	mine	cause (Disease or injury that initiated events								
/ @ a + resulting in death) Last Due to (or as a consequence of):								41			
58760,	ate be hysicia he bu	ical		d							
_	ertifica ling pl	Medi	IF FEMALE:	20- 16							
X Q Q	death certi e attending d for use a	Physician/M	in the past 12 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	4		23d. Date of d	Day Year	
o.	0 0	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□Unknown	unie or dedut - OE						
	requires that the een signed by th hould be detache	by Pł	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
ğ	w require been slg should b							1 ☐ Ye	es 2 No 3 I	Probably 4 nknown	
Hecords,	law as b	Completed						24a. Was ar autops	y prior to	autopsy findings available completion of cause of	
E E	ate pag	Con						perform	ned? death?	es 2 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 3000A Oth	w.	th Check onl one		Hospico	
ō	Phys rrthis aral dii	To	1 Yes 2 No 27. Mapper of Death	28a. Date of Inju	ry 28b. Time o	11 3 DOX	4 LI Nursing He		ence 6 XOther (Sp ow injury occurred	Decify) Hospice	
0	nding Prith. r: After the funeral	ation	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injury		rk? Yes 2 □ No				
DIVISION	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injuding, et	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or in, State)	Rural Route Number,	
5	ital or after all bi								()		
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical			of my knowledge, deat f examination and/or ir ated.						
	To the within To the compl	Me	29b. Signature and title occertifier		4 ()	29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)	
)			> Thank C	Ny	-mD	Po	05955	2	7/23/0	2008	
-	10		30. Name and address of person who c			Print)	RD WE	-C-12	700		
	Sta	te.	31. Date filed (Month, Day, Year)		ar's Signature	4 pook	NU UC	אלא חון ב	9<		
	Registr		1111 2820		w It A	reck					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carroll 2008 16:25 Donald /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore 705017 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 → M 2 □ F **Director** 57 <u> 214-54-6660</u> 08 51 MD 04 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentai Hygiene.

The mast standard in the "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar in sall be notified at Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 519 Normandy Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No !f Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gray & Sons Cement Finisher 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Fraction ٩ James Carroll Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 21229 516 Normandy Ave, Baltimore, Md James Carroll Sr.-Father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of H Important: If Ite any injury or ot 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/29/08 Woodlawn, Md 21. Signature of Funeral Service Licensee March ant offs West 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. -ardiac Immediate Cause (Final disease or condition resulting in death) **Physician** 10 mins /Medical Due to (or as a consequence of):
NDR Pseudomonas **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: / 2 ☐ Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated P22002 July 22,2008 death (Item 23a) (Type, Print)
900 (atom Ave Baltimore MD 21229

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-003	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hydiene	
}	Phy /M Exa	si lec
ilon or vital Records, P.O. Box 68/60,	anding Physician: The law requires that the death certificate be executed	After this certificate has been signed by the attending physician and

			For State of Maryland / E State Registrar		rtment of He tificate of D		/lental Hy	giene Beg No.	2008	24145
			Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
	Physicia /Medic	_	VIRGINIA LIPSCOMB COX				July	19	, 2008	8:45 A. M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c.	County of Deatl	h
	Funeral		Keswick 5. Social Security Number	rthday)_	If Under 1 Year	imore if Under 24 Hrs.	8. Date of Bi	rth	N/A 9. Birti	hplace (State or Foreign
	Director		215-05-3758 1□M 2∏F 88	Yrs.	Months Days	Hours Min.	Jan. 3	$\frac{19}{192}$	20 Vir	ginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	vn or Loc	ation					10d. Inside City Limits
	Maryla f sho led at	to		1tim	ore					1 X Yes 2 □ No
	h the	Director	10e. Street and Number	T CTIII	10f. Zip Code			10g. Citi	izen of What Co	untry?
	23a c ust be		700 W. 40th. Street		212				U.S.A	
	er dez items ner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	 Race - Ame Black, White 	
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show int, the Medical Examiner must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes, 2 ▼ No If Yes, Give Year or Dates:	1	□Yes 2√∑No	Specify:			Specify: W	hite
	72 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	. Decede	ent's Usual Occupa aind of work done of O NOT use retired	ation Juring most of work	king	16b. K	ind of Business/	Industry
7	within and " than " than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		on of Volument	_			Hospita	.1
2	filed Hygid		12 years DIT	rect	OL OI VO.	18. Mother's Nam	ne (First, Middle	, Maiden		11
<u></u>	should be nd Mental s marked o	To Be	Edwin Lipscomb			Anna		Bag	gget	
<u> </u>	2 sho l and ? is ma rauma				g Address (Street a			-		
ב ט	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Memlal Hygiene. I then 21 is marked other than "natural", or items 23a or 28a-f show then 27 is marked other than "natural" or items 20a or 28a-f show other traumatic event, the Medical Examiner must be notified at				Colonia	<u>l_Drive_</u>	Mount A		Maryla ocation - City or	
5			cemete	ery, crem	nt Crema	e) tomi Julv	23,2008		Ť	, Maryland
	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. M	Name and Addres itchell—1 6500 Yorl	s of Facility Wiedefeld		al Ho	ome. Inc	. ratytana
	20 E # 9		23a, Part1. Enter the sease or complications that caused the death. Do		6500 Yorl	k Road	Baltimo	re, l	Maryland	1 21212
	Zévis		23a. Part I. Enter the issesse or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
}	Physician /Medical	4	disease or condition resulting in death) a. Due to (or as a consequence	of):						4098)
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	: of):						
5	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence	of):						
	ate be hysicia the bur	edical	d							
5	certific ding p	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy		·				001 P-1(1-	
2	death certif	sician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No		Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
į	ires that the de signed by the a I be detached i	Physi	9 ☐ Unknown							
<u>.</u>	res tha	by	Part II. Other significant conditions contributing to death but not resulting in	in the un	derlying cause give	en in Part I.				o the cause of death?
	w require been sign	eted					24a. Wa			utopsy findings available
ב	he lav e has age 2	Completed					aut per	opsy formed?_	prior to death?	completion of cause of
		Be C	25. Was case referred to medical			26. Place of Dea	1□ Yes ath (Check only		o 1 ☐ Yes	2 10 10
× 1	hysic this ce	To E	examiner? 1 Yes 2 Ano Hospital: 1 Inpatient 2 ER/Ot			4 Nursing F	7		6 □Other (Spe	ecify)
=	ding Physician: The		1 Natural 5 Pending (Month, Day Year)	. Time of Injury	28c. Injur Worl	yat k? Yes 2∐No	28d. Describ	e how inju	iry occurred	
	Attency death	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa	farm, stre			28f. Location	(Street a	nd Number or F	lural Route Number,
5	tal or is after al Dire	Certification:	4 Homicide determined building, etc. (Specify)				City or I	own, Stat	re)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical (29a. Certifier 1 Secrtifying Physician: To the best of my knowledg (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.							
	To the within To the comple	Med	29b. Signature and title of certifier		29c. Licens	e number			ate signed (Mon	
			pron Blads MD		Do	06 11 99		Ju	14,20	, 2008
	4		30. Name and address of person who completed cause of death (Item 23a) 23a. Marne and address of person who completed cause of death (Item 23a) 23a. Marne and address of person who completed cause of death (Item 23a) 23a. Marne and address of person who completed cause of death (Item 23a) 23a. Marne and address of person who completed cause of death (Item 23a) 23a. Marne and address of person who completed cause of death (Item 23a) 23a. Date filed (Month, Day, Year) 23a. Date filed (Month, Day, Year) 23b. Date filed (Month, Day, Year)	(Type, I	Print)	Suite 20	9 (70	(, ())	MA	21204
	Sta		31. Date filed (Month, Day, Year) 32. Rejistrar's Signature		1			~,~	1000	
	Registr	ar	JUL 2 8 2008 Street St.	15	aces.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** <u>~2008</u> 8:137 2 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice altimore If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number **Funeral** Days Min Months 410-44-0923 1928 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No ral", or items 23a or 28a-f sl Examiner must be redified by Funeral Director CWEO! 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ev Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ Ne Specify: 3 ₩idowed 4 Divorced "natural" Completed the Medical 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) Prep Dealership i. Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If Item 27 is marked other th ijury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Chism Carrie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 2036

Date 20c. Location - City or Town, State 35Stoneway K Melvina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bofial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. 7.200.2008 Towson MI 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Vaugn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York ad Bullimore, MJ 21212 reene 23a. Part 1. Enter the tivease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed as the burial-transi Due to (or as a consequence of): O. Box 68760, Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 2 🖪 No 3 Probably 4 Unknown cate has been si, page 2 should b 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: The Division of Vital 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

I Director: Af in by the fur 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide Hospital e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md ZIZOX G BMC 6761 (1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 8 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Deçedent's Name (First, Middle, Last, 2. Date of Death Day Year **Physician** 2036 700 X /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Ba (fimore 105 D: fal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. [ast birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🗓 F Days Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County Town or Location 10d. Inside City Limits 10c. City, 28a-f show injury or other traumatic event, the Medical Exacting must be notified at 1XYes 2 □ No **Funeral Director** Ure 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or items 23a or 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life; DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry it of Health and Mental Hygiene. If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Roote Number, City or Town, State, Zip Code) MOT7 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Method of Disposition 1 Burial 2 ☐ Cremation permit. Page:
Department o
Important: If |
any injury or
once. 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** asthma exacerbation nnknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thicklying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death the 9 HInknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an performed this certificate 2 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Yes Yes 2 🗆 No 2 NER/Outpatient 3 □ DOA 1 Inpatient Certification: To funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier 29c. License number D8066118 MD

State Registrar 30. Name and address of Jerson who

31. Date filed (Month, Day, Year)

Cmar, MD

JUL 2 8 2008

Ave.

completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Month **Physician** July 25, 1:15 A M 2008 Robert C. Cassin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care - Potomac Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 1, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days Months 1 ☑ M 2 ☐ F Vermont 86 Director 009-07-7231 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylai th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, If a Medical Evanthar must be notified at 1 ☑ Yes 2 ☐ No Rockville Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 United States 118 Monroe Street #707 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 25 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Marketing Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Frudenthal Charles Cassin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any Injury or other traur 118 Monroe Street #707, Rockville, Maryland 20850 Lydia Cassin/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Rockville, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial 2008 4 ☐ Donation 5 ☐ Other (Specify) Pumphrey Funeral Home/ 22. Name and Address of Facility Robert A. 21. Signature of Funeral Service Licens Inc. 300 West Montgomery Avenue Rockville; 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician end for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) P.0. ed by the detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Leucocytosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The certificate | 2X No 1 ☐ Yes 2 ☐ No 1 TYes Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1∐ Yes 2√∑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054566 July 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue Suite 1-17, Silver Spring, MD 20902 Sunitha Bhogavilli M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 28 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep	artment of Health and I ertificate of Death		ene g. No. 2 N N S	21,11,0
1	10.5	Щ	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici Medie		Doris Anna Derr		July	24 2008	7:21 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	<u> </u>		Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A	place (State or Foreign
	Funeral Director		1 M 2	Months Days Hours Min.	Month, Day,	Year) Coui	aryland
М			215-30-5763 Usual Residence of Decedent		Movember	17,1901 11	aryrand
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	or 28	Dire	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	
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36	ırs afi II', or xami	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₹ No If Yes, Give A 3 🖾 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	te
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medikal Examiner must be notified at	Completed by Funeral Director	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	rking 1	6b. Kind of Business/In	dustry
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and	be fil tal H d oth even	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
ž	hould d Mer narke natic	户	Thomas J. Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ing Address (Street and Number or Ri		uresch	Code)
Maryland	d 2 sl th an t7 Is r traur					Maryland 2	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		, ,	position (Name of ematory or other place)		20c. Location - City or T	
Baltimore,	Pages nent of H ant: If ite		14-1 Bunal 2 Li Cremation 3 Linemoval from State	y Redeemer Cem. 7	/28/08	Baltimore,	Maryland
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m	Departi Departi Import any ir		Busia Cuce 9	705 Belair Road	Baltimor	e, Maryland	1 21236
П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	rivatory Failure		1.2	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	, pm 1			,
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	nsit ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	les Parers.			14000
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Вох	leath certifi attending	an/I	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	*
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or Vital Records,	v requ been shoul	Completed			24a. Was an	24h Were aut	opsy findings available
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Division	or Att fter de Direct n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str City or Town	reet and Number or Ru ı, State)	ral Route Number,
	pital ours a eral C		29a. Certifier 1× ertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the ca	auco(e) and manner ac	etated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.				
	Fo the vithin Fo the compl	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month	, Day, Year)
	/		MA	D3405	3	July 25	1,2008
	4	1	30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	_		
		1 (1)	31. Date filed (Month, Day, Year) JUL 2 8 2008	dale 2 YTY Kel	code et	Rue falt	am
	s Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Carolin I			
Į.	Regist	ar	JUL 2 8 2008				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:27 PM 19 July 2008 Davis Shekeyrah Niyell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bathmore Sinai Hospita If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2X F Yrs 11 05 16 MD 218-49-0583 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 2503 Shirley Ave Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black à 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student School 5th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Larry Watson Kimberly Davis 19a. Informant's Name/Relationship (Type. Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and :
Department of Health
Important: If Item 27 i
any injury or other tra of Health 2503 Shirley Ave, Baltimore, Md 21215 Kimberly Davis Watson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 7/29/08 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Immediate Cause (Final **Physician** Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of):

Chem thereso Examiner Sequentially list conditions, if any, leading to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 □ Yes 2 No 3 Probably 4 Unknown Irisomy ZI Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b director. 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A d in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Aaron Zuckerbery,

31. Date filed (Month, Day,

ORIGINAL

29c. License number 29d. Date signed (Month, Day, Year)

2401 West Belvedere Ave, Baltimore, Md 21215

30. Name and address of per on who common deauth (Item 23a) (Type, Print)

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	Physicia		1. Decedent's Name (First, Middle, La	st)) s x0.	41		Date of Death Monfi Da	Year Pour	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)	· / \\	4b. City, Town, or L			c. County of Death	
a compa	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthda	y) If Under 1 Year	MOFE If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year	9. Birthr	place (State or Foreign
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	signed I be det	þ	Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying cause giver	n in Part I.			the cause of death?
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		Comp						autopsy performed: 1 □ Yes 2 🔼	? death?	ompletion of cause of 2 No
Vita sician:	s certifii irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital:	t 2 ER/Outpa	Other	26. Place of Death (6 ☐ Other (Spec	r/fu)
ר Of Phy	h. After this funeral d	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,	28b. Time	e of 28c. Injury	at 28	d. Describe how in		July)
Division of	death. ctor: A y the fu	icatio	2 Accident investigation 3 Suicide 6 Could not	e 290 Place of Injury	At home, farm.	M 1 □ Y street, factory, office	'es 2 □No 28	f. Location (Street	and Number or Ru	ıral Route Number,
Div talor	s after d al Direct ed in by	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	ate)	
Division of Vita the Hospital or Attending Physician:	within 24 hours al To the Funeral D completely filled i	Medical	29a. Certifier (Check only one)	hysician: To the best of iminer: On the basis of eand manner state	examination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To the	within To the comple	Med	29b. Signature and title of certifier	/		29c. License			Date signed (Month	
	1		· CODE	Coll		019	5870	2 00	My 21	2008
5			30. Name and address of person who	Bobne	25 (Typ	Maja 5	Free	211	136	
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 2 8 2	completed cause of dea A Registrar'	's Signature	naule				
	gioti	-41	JUL 2 0 20	A Comment						

		Please	Type or Pri State of M						lental Hy	giene			
	1	1 - State Registrar			Cer	tificate d	of Deatl	h		Reg. No. 2	2008	24	152
Physicia		1. Decedent's Name (First, Middle, La	ast)						2. Date of De Month		Year	3. Time of	
/Medic		Elsie Joy Emer							July			4:05	A M
Examin	er	4a. Facility Name (If not institution, gi Gilchrist Center	for Hospi	ce		4b. City, Town				Ba	ounty of Death	3	
Funeral			Sex 7. A 1 □ M 2/CXF	ige (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Bir (Month, Da 04/01/	th ly, Ye <i>ar)</i> 1027	Cou	place (State o intry) nsylvar	
Director		163–30–3996 Usual Residence of Decedent		71	1101				04/01/	1937	Peru	isyrvar	IIa
yland		10a. State 10b. County	-	10c. City, To	own or Lo	cation	-					10d. Inside Ci	
Mar ma-f sl	ctor	Maryland Baltimo	re	Essex	X							1 □ Yes	2 X No
ith th	Öire	10e. Street and Number				10f. Zip Cod					en of What Cou	intry?	
s 23a	ral	1900 Grove Manor			1.0.1	212		0 : :-0 /0-		U.S	A. Race - Amer	inon Indian	
ter de item:	Funeral Director	11. Marital Status 1 ☐ Never Married 2 Ă Married	12. Was Deceden Armed Forces 1 Yes 2	?	13.	Nas Decedent f Yes, specify (of Hispanic (Cuban, Mexic	origin? (Spean, Puerto	Rican, etc.))- [12	Black, White		
urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1⊡Yes 2⊠	No Speci	fy:		8	Specify: White		
72 hor	Completed	15. Decedent's E (Specify only highest g	Education	1	6a. Dece	dent's Usual O	ccupation	ost of work	ina	16b. Kind	of Business/l	ndustry	
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iled w Hygie ther ti	S	12 17. Father's Name (First, Middle, Las	**)		Assor	ter	18 Mo	ther's Name	e (First, Middle			<u> </u>	
d be feat all ced o	To Be	Gilbert Robey	·•/					ie En		,	,		
shoul ind M mari	ř	19a. Informant's Name/Relationship	(Type. Print)	1	19b. Mailir	ng Address (St	reet and Nur	nber or Rur	al Route Numb	er, City or	Town, State, Z	ip Code)	
and 2 salth a 27 is		Merle Emerick (H	usband)	-	1900	Grove 1	Manor	Drive	, Apt.#	¥324 ,	Essex,	Md. 212	221
of He		20a. Method of Disposition	Romoval from Stat	20b. Place ceme	e of Dispo etery, crer	sition (Name o	of place)	[Date	20c. Loc	ation - City or 1	Town, State	
Pag tment tant: jury c		20a. Method of Disposition 1											nd
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evanimet must be notified at once.		21. Signature of Funeral Service Lice	onson		22	2. Name and A	Bruzdz	inski	Funera	al Hor	ne, P.A	 	1 2 2 1
	1	23a. Part I Inter the disease, or cor	mplications that caus	ed the death. I		1407 Old					k, Mary	Approximat	te
Physician		stock, or heart failure. List onl Immediate Cause (Final	y one cause on each	line.	2 A	NOSE	2				-	Interval Bei Onset and	
/Medical		diséase or condition resulting in death)	a. Due to (or a	as a consequen	ce of):	VCC						04 9 6	0.0
Examiner	_	Sequentially list conditions.	b										
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequen	ce of):								
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eath certificate battending physic for use as the b	Physician/Medica	IF FEMALE:											
ath ce	ian/l	23b. Was decedent pregnant in the past 12 months?		n 2 🗆 Fetal de	eath 3	Ectopic preg				2	3d. Date of del Month	,	Year
he de	ysic	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnan 9 ☐ Unknowi	t at time of deat n	th 5L	Other (speci	fy)						
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w requires been sig should be									1 🗆	Yes 2]No 3□Pi	robably 4	Unknown
e law requ has been le 2 shoulc	plet								24a. Wa	s an opsy	24b. Were au	topsy findings	available cause of
ding Physician: The lav h. After this certificate has funeral director, page 2	Completed									ormed? 2. No	death? 1 □ Yes	_	
iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othor:		th (Check only		X	Нас	2000
Phys rr this rral dii	: To	1 ☐ Yes 2 No 27, Manner of Death	1 ∐ Inpa		R/Outpatie		Injury at Work?	Nursing H	ome 5 Res		occurred	icify) (165	rice
nding ath. r: Afte e fune	atior	Natural 5 Pending 2 Accident investigati		Day, Year)	Injury	М	Work? 1 □Yes 2	No					
r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At home etc. (Specify)	e, farm, st	reet, factory, of	fice			(Street and	Number or R	ural Route Nu	mber,
urs aft rral DI		7										1-1-	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical		Physician: To the be aminer: On the basi and manner	s of examination									(S)
To the vithii To the comp	ž	29b. Signature and title of certifier	200	\		29c. L	icense numb	er		29d. Dat	e signed (Mon	th, Day, Year)	e)
15		Rendal	LKY	-cerll	ler	0 1	0.00	04-5	>	01	1201	700	Ŏ
5	(30 Name and address of person wh	o completed cause of	of death (Item 2	3a) (Type	Print)	11.15- 1	trum	Bud	1200	o to ma	160	204
Sta	te	31. Date filed (Month, Day, Year)	32.	istrar's Signatur	6	0.10	W SA	700,		- CC		200	W- 1
Registr		JUL 2 8	2008	era L	1 6	melle							

DHMH 17 Rev 1/2001

	 Registi
	1. Decedent
Physician /Medical	Ju.

Certificate of Death

3. Time of Death Day Year

Funeral Director

death with the Maryland , or items 23a or 28a-f show event, the Medical Examiner must be notified at filed within 72 hours after 'natural', Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than " permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed the burial-transi hours after death Director: within 24 hours a

t's Name (First, Middle, Last) 2. Date of Death lia B. Ford 7:07 A 2008 July 24 a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours Days 1 □ M 2 🖾 F 72 January 25, 1936 Pennsylvania 220-34-9088 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5213 Drake Terrace 20853 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify ð Specify: 3 ☑ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harley B. Buckingham Eva E. Aiello ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie C. Beiter / Daughter Gaithersburg, Maryland 20879 19704 Drop Forge Lane 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery July 28, 2008 Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 W. Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service 1 M00896 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disr ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in thillure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction hour disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 🗆 No 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier (Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier Joseph M. Haggerly

29c. License number

D32407

29d. Date signed (Month, Day, Year) July 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Haggerty, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850 32. Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

2008

7

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	_	For State Registrar		State o	f Marylan	d / Depa <i>Cer</i>	rtment of H tificate of L	lealth and D <i>eath</i>	Mental Hy	giene, Reg. No. C	2008	24154
Physicia		1. Decedent's Name (Fi	irst, Middle,				NKA		2. Date of De Month July		2008	3. Time of Death 2:35 A. M
/Medica		4a. Facility Name (If no	t institution,	give street and nu	mber)		4b. City, Town, or	Location of Dea		4c. C	County of Deat	h
		Gilchris					Towso	n If Under 24 Hrs	To Date of Bi		altimor	thplace (State or Foreign
Funeral Director		5. Social Security Numb		.Sex 1□MXXXF	7. Age (In yrs. 94	last birthday) Yrs.	Months Days	Hours Min		ay, Year) 28,191	3 Mar	yland
		Usual Residence of Dec	cedent			. Town or to	ation					10d. Inside City Limits
Aarylar f shov	ō		b. County			y, Town or Lo 1timor						XXYes 2 □ No
r 28a-	Director	10e. Street and Number					10f. Zip Code	·		10g. Citiz	en of What Co	untry?
tth witt		18 East La	ake_Av	enue			21212	2			U.S.A	.•
er des items	Funeral	11. Marital Status	2	Armed Fo		.S. 13. \	Vas Decedent of H fYes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 1	 Race - Ame Black, White 	
urs aft al", or	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		d 1 □Yes If Yes, Gi Year or D	ve		I∐Yes XXX	Specify:			nite	
72 ho	eted	15. (Specify o	. Decedent's	Education grade completed)		(Give	dent's Usual Occup	during most of wo	orking	16b. Kin	d of Business/	Industry
within ene. than	Completed by	Elementary/Seconda	ry (0-12)	College (*	I-4or 5+)	1	oo not use retired nemaker			me		
al Hygi other vent, t	Be C	17. Father's Name (Firs	st, Middle, La	ast)		1		18. Mother's Na	ame (First, Middle	e, Maiden S		
Menta Menta arked	2	Michael			(Gackows		Victor				owalski
and 2 should be filed within 72 hours after death with the Maryland aeth and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examirer must be notified at		19a. Informant's Name Ernest G1:		p (Type. Print) (son)		1	ng Address (Street ast Lake					
of Hea of Hea item 2		20a. Method of Disposi	ition	_	1 /	Place of Dispo	sition (Name of natory or other place	T.	Date		cation - City or	
Page ment ant: If		12XBurial 2 □ C 4 □ Donation 5 □			State	ly Ros	ary Cemet	tery 7-	30-08			Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funer	al Service L	bense		22	2. Name and Addre		tchell-V d Baltin			
TIE.		23a. Part 1. Enter the c shock, or heart fa	disease, or o	mplic con that only one conse	caused the deat	h. Do not ent						Approximate Interval Between
Physician		Immediate Cause (Findisease or condition resulting in death)		_ a§	SEPS	15						Onset and Death
Medical Examiner		rosaling in dodaily		Due to	(or as a conseq	uence of):					1	
P #	ner	Sequentially list conditi if any, leading to immed cause. Enter Underlying	diate	b. Due to	(or as a conseq	uence of):						
xecute and I-transi	Examiner	that initiated events resulting in death) Last	ry T	C	(or as a conseq	mence of)						
icate be executed physician and s the burial-transit	Sal E			, see 10	(5) 45 4 5011504	jucitoc oi).						
	Medical	IC CEMALE.	William A.	U					1			
or Attending Physician: The law requires that the death certifuted death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pre in the past 12 mo	egnant nths?	1 Live	tcome of pregn birth 2 Teta	al death 3	Ectopic pregnanc	су		2	23d. Date of de Month	elivery Day Year
uires that the de signed by the a d be detached f	ysic	in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	0	4 □ Preg 9 □ Unki	nant at time of	death 5 L	Other (specify) _					
ss that gned b	by Pi	Part II. Other significa				sulting in the u	nderlying cause giv	en in Part I.				to the cause of death?
w require s been si should t		KENAL		TILURE					- 1	Yes 2	No 3 F	Probably 45 Unknown
ne law has b ge 2 sl	Completed	DE21	<u> </u>	7					- 24a. Wa aut per	s an opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of
an: TI rtificate tor, pa	Be Co	25. Was case referred	to medical					26. Place of D	1 □Yes leath (Check only	2 No	1 □ Ye	s 2 No
hysici his cel		examiner? 1 ☐ Yes 2 No		Hospital: 1	Inpatient 2] ER/Outpatie	II 3 DOA	ner: 4 🗆 Nursing	Home 5 ☐ Re		6 Other (Sp	ecify) HOSPICE
ding P. After t	ion:		5 ☐ Pending investiga		of Injury oth, Day, Year)	28b. Time o Injury	Wor	ryat rk?]Yes 2 □No	28d. Describ	e how injur	y occurred	
Attender r death	Certification: To		Could no determin	.	of Injury - At h	ome, farm, st	reet, factory, office	1162 2 110	28f. Location	(Street an	d Number or F	Rural Route Number,
ital or irs afte al Dira led in I	Cert	4 Homicide								own, State		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	Certifying Medical E	xaminer: On the I	e best of my kn basis of examin nner stated.	owledge, deal ation and/or in	th occurred at the to extraction, in my	ime, date and pla opinion, death o	ace, and due to the courred at the time	ne cause(s) le, date and) and manner and du	as stated. ue to the cause(s)
To th within To th comp	Me	29b. Signature and title	e of certifier	00			29c. Licen	se number	2	29d. Dat	te signed (Mor	nth, Day, Year)
1		Pyzen	acel	- Kra	ulle	~ 03=) /T	Brief)	7064	>	01	120/	2000
H		30. Name and address	_	tho completed cau	ND (Ite	m 23a) (Type,	. Towsan	teren	Blod/ &	3004	OMO	21204
Sta		31. Date filed (Month,	Day Year)	008	Registrar's Sign	ature	Print) . Towscu					
Registra	ar	JUL	M O L	100		3						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

þ

Be Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Department of Health ar Important: If Item 27 is any injury or other trau

Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite

3altimore, Maryland 21215-0036

death

Immediate Cause (Final disease or condition resulting in death) Physician /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Physician/Medical the as nse 23b. Was decedent pregnant for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed page 2 director, 25. Was case referred to medical examiner? Be 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

To the

After

within 24 hours at er deat To the Funeral Director

State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item_23a) (Type, Print)

1210110

Road Westminister MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 20 66 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number **Funeral** Days Months 1 - M- 2 - F 227.38.6998 AV Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No-Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S.
Armed Forces?
1 Des 2 No
If Yes, Give
Year or Dates. 21286 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours atter 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Engineer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Hawkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Basin Rd New Costle DE 19720 Chestnut <u>onstance</u> 80 E permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-20-2008 Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vougno C Oreene Foreral Services 21. Signature of Funeral Service Licenses Kreene 4905 York And Baltimore, MD 2012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) attending physician use as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No detached 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Physician: The certificate 2 No 2 🗆 No ∣∐Yes 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' OSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident I hours after death uneral Director; 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar N- Charles St. Balts and Z. 20%

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 2 8 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician Month 30 AM essie ec Hairston 2 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes HUSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 96 Days Hours Months Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show unt. If Item 27 is marked other than "natural", or Items 25a be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No ti more Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working (iii). DO NGT use settled) 15. Decedent's Education (Specify only highest grade completed) y/Secordary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle Her's Name (First, Middle, Last) Maiden Surname Be 0 sreen Informant's Name/Relationship 20a. Method of Disposition Department of Important: If it any injury or conce. Burial 2 Cremation
Donation 5 Other (5 3 Removal from State 5 Cher (Specify) 21. Signatu Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumons /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I within 24 hours after death.

To the Funeral Director: After this completely filled in both. certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 TYes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item(33a) (Type, Print)

State Registrar MAN

31. Date filed (Month)

28 2008

4Airston,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 07-21-2008 **Physician** 315 A M Sylvia Sue Jacobsen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 355 Catherine Street Bel Air 8. Date of Birth (Month, Day, Year) 01-19-1932 Birthplace (State or Foreign Country)
 KY If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours 1 □ M 2 🗓 F 213-28-0058 76 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21014 355 Catherine Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George B. Schirmer Rosa N. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21220 Barbara Pine (Daughter) 4016 Chestnut Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-22-2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Solvice Licenses 610 W. MacPhail Rd Bel Air, MD 21014 Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl for use as t IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2

State Registrar

Tollgate 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

JUL 28 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29c. License number

Rd

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

		•	For State Registrar		Olale 0	iviaiyio	C	ertificat	e of l	Death		Reg. No.	008	24159
П	Physicia	20	1. Decedent's Name (F	First, Middle, Las				-			2. Date of De	ath Day	Year	3. Time of Death
	/Medic		Mary			rrain	ıe			dan	07	23_	2008	
*E	Examin	er	4a. Facility Name (If no					1		Location of Death		4c. Cou	inty of Death	1
,-	Funeral		Future Ca 5. Social Security Num	ber 6. S	ex	7. Age <i>(In yr</i>	s. last birthd	ay) If Under	1 Year	If Under 24 Hrs.	8. Date of Bir	th ,	9. Birth	nplace (State or Foreign
	Director		219-38-1 Usual Residence of De	65T	□ M 2	67	Yrs	Months	Days	Hours Min.	(Month, Da	_	Cou	MD
vlanc	how		10a. State	b. County		10c.	City, Town or	Location						10d. Inside City Limits
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ns after d	Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Exercitant into Leadilland at once.	by Fun	1 ☐ Never Married 3 ☐ Widowed 4 ☐	4.4	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? No		If Yes, spe 1 □ Yes		lispanic Origin? (S) an, Mexican, Puerto Specify:	Rican, etc.)		Black, White ecify: B1	, etc.
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y k	and Mark	Ĕ	19a. Informant's Name				19b. M	ailing Address	(Street	and Number or Ru			wn, State, Z	?ip Code)
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Dan de	Depar mpor any in		21. Signature of Funer	al Service Licer	isee			22. Name at		ss of Facility H West ash Ave			N 7	21215
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To the Hospital or Attending Physician: The law requires that the death cer	signed by the attendir I be detached for use	Physician/N	IF FEMALE: 23b. Was decedent print the past 12 mo 1 ☐ Yes 2 ☐ M 9 ☐ Unknown	nths?		oirth 2□F nant at time o	etal death	3 ☐ Ectopic p 5 ☐ Other (s	oregnand oec <i>ify)</i> _	;y		230	I. Date of del Month	ivery Day Year
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The law re	h. After this certificate has be funeral director, page 2 sho	Completed									24a. Was auto perfe 1 □ Yes	s an ppsy ormed?	24b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 24160 Clarence Jackson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3 Time of Death Month Medical Examiner 0915 hrs Jackson July 20, 2008 Clarence Vincent 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5708 Beechdale Avenue Apt. D **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min Director 150-34-5571 01 04 47 Country) NJ 1X M 2 F 61 Yrs Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show NA Baltimore MD or items 23a or 28a-f shore. must be notified at once. Director 10e Street and Number 10g. Citizen of What Country 10f. Zip Code 21239 U.S.A. 5708 Beechdale Ave Apt D Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death varieties of feath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes 2 Black 4 X Divorced If Yes, Give Year 3 Widowed Yes 2 X No specify: Specify: Ex iminer <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Various Jobs Security 12th grade na 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louise J. Jackson Be Bert Quille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21239 1525 Northbourne Road, Sandra L. Fletcher-Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 Removal from State crematory or other place) Department of Important: 7/24/08 Baltimore, Md P Donation 5 Other Specify. Crematory 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee 21215 Baltimore, Md 23a. Part I. Enter the disease, or complice ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit /sician/Medical X AMENDED PII per me g881 7/31/08 TT UNPENDED ending physician use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day 2 Pregnant at time of death Box 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown g Unknown 둳 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ó ð σ. 1 Yes 2 No 3 Probably 4 V Unknown Cancer Completed Records, has been si 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate h ector, page 2 Yes 2 V No 25. Was case referred to medical funeral director. 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 2 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural death. 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) filled determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. July 20, 2008 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day Year) 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State 8 200

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State of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 24162 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A M David Johnson 12 2008 文 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death NA If Under 24 Hrs. If Unde Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) last birthday) **Funeral** 7. Age (In yrs 1 □ M 2 □ F Months Days Hours 217-40-27/6 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore Director 1 Yes 2 No 10e. Street and Number Edmondson 10f. Zip Code 10g. Citizen of What Country? 21223 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items any injury or other traumatic event, Item Madical Evan ner man Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No ģ Specify 3 Widowed 4 □ Divorced Specify Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Keal E state kinitorial Services NA 1th Grade 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be lohnson bone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) heila 21206 MD. erman altimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07-29-08 Baltimore, MD of ☐ Other (Specify) 4 Donation dge 2140 North Fulton Avenye MD. 21217 21. Sign of Fun ral Service Licer 22. wime and Address of Facility Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Preumonio Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: he law requires that the death certificate be executed burial-transif Immune deperient End Stage
Due to (or as a consequence of): End signed by the attending physician and deed detached for use as the burial-trar Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has I autopsy this certificate 2 🔲 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔼 🐪 0 မ 1 Unpatient 2 ER/Outpatient 3 DOA funeral within 24 hours after ueau...

To the Funeral Director: After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, ho comp ed cause of death (Item 23a) (Type, Print) 30. Name and address of per 31. Date filed (Mont Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY Day Year 2008 **Physician** 11:27 M Ernest Jones, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 01/02/1946 238-76-0562 NorthCarolina Director 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nutfilled at 1√Xes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 21230 U.S.A. 3019 Janice Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify. White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ages 1 and 2 should be filed within 7 nt of Health and Mental Hygiene.
If item 27 is marked other than "n. or other traumatin event. Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Jones Mary Ellen Lowery ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3019 Janice Avenue, Baltimore, Maryland 21230 Mohini Jones (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/29/2008 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21 Signature of Fundral Septime Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm - liate Cause (Final dis - se or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to instruct the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>გ</u> 1 Tes 2x No 3 Probably 4 Unknown Completed MULTIPLE STROKES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 No 2 15 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ė 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Oirector A

completely filled in by the fi fter death 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON MARYLAND 31. Date filed (Month, Pay,) BOON POH LIM. M. D 7601 32. Registrar's Signature ^{Year)} 8 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 [] [] 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gustavia Μ. Jackson 2008 23, July | 2:03 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 💢 F Days 82 Director 466-36-7415 Jan 16, 1926 Washington, LA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3019 Great Oak Drive Funeral 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ 3 Widowed 4 □ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jackson Rosa Terry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other to Janice M. Lewis / Daughter 3019 Great Oak Drive, Forestville, MD 20747
ace of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery July 31,2008 Beaumont, Texas 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appendict Course (Fig. 1) Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial ly tauctions **Physician** Thour /Medical resulting in death) Due to (or as a consequence of): **Examiner** terio Schero Sta esquentially fee conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed tensioni use as the burial-trai P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: '4 hours after death. Funeral Director; After this certifica lely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MO

CHAMPALOUX

JUL 2 8 2008

6.

31. Date filed (Month, Day, Year)

Opper Marlboro

MUS

YORN HOSHAUT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05561 2008 24165 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death Reg. No 1- For State Registrar 2. Date of Death 3. Time of Death Johnson-Mosby Ruby L. Month Day July 20, 2008 Physician/ 2254 hrs Medical Examiner 4c. County of Death . City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1289 Limit Ave. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min Country) 23 684 Director 212-11-4 Yrs М Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County 1 Yes 2 No timore hours after death with the Maryland 10g. Citizen of What Country rector 10f. Zip Code 10e. Street and Number 210 ۵ 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 11. Marital Status or items Armed Forces? 2 X Married Never Married Yes Yes 2 No specify: f Yes, Give Year Divorced 3 Widowed "natural" 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hous.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturinjury or other transmatic event." Completed College (1-4 or 5+ Elementary/Secondary (0-12) 's Name (First, Middle nomas Be unason or Town, State, Zip Code Rural Route Number (Street and Num 9b. Mailing Address 21217 1018 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other blace) 2 Cremation 3 Removal from State ation 5 Other Specify etu of Fun License Approximate Interval Between Onset and disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Entertite disease, or complication failure. List only one cause on each line. Physician Death /Medical Multiple Sharp Force Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Couse Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and trai Physician/Medical UNPENDED X AMENDED Iten#1,perME,G882,8/2/08,WS signed by the attending physician be detached for use as the burial 23d. Date of delivery P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ğ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, prior to completion of cause of this certificate has been il director, page 2 should autopsy death? performed? 1 🗸 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Residence 6 V Other: Scene Be Other₄ Hospital: 1 Nursing Home 5 examiner? DOA Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28h Time of Injury 27. Manner of Death Subject assaulted After FOUND: Yes 2 V No Natural Pending death. Jul 20, 2008 2230 hrs in by the Director: 28f. Location (Street and Number or Rural Route Number, City Certificati Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 1289 Limit Ave., Baltimore, MD Could not be 3 Suicide (Specify) Townhouse / Rowhouse determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME July 21, 2008 O.C.M.E. 30. Name and address operson who completed cau a of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32 Registrar's Signati 31. Date filed (Month, Da

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:35 ₽м 2008 Allen Rayfield Kirby Sr. Ju1v /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Febr. 28, 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F 220-01-8234 89 Mary1and Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6451 N. Charles St. 21212 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: WW II 1 □ Yes 2**X**No Specify: 2 3 X Widowed 4 □ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in ment of Health and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any linjury or other traumatic events. Annie Fischer James Kirby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 2202 Eastridge Rd. Timonium, MD Allen R. Kirby Jr./son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gard July 30,2008 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland John O. Mitchell IV, Funeral Services of Dulaney Valley, P.A.200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Fungral Service Licensee Mitchell Approximate Interval Between Onset and Death 23a. Part Conter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final 4 days **Physician** Complication disease or condition resulting in death) /Medical Due to (or as sconsequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a conse juence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ■ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred Facility Stoff
Noted poin with tronsfer which
led to m x-ray which diagnosed the F 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 No death. MKnown investigation 2 Accident Unknown filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Brighton Gardens Assisted Living Facility 6451 N. Charles St. Balto. Md Z120 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 24, 2008 30. Name and address of person who computer cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 GAMIC 6701 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town Examiner Saltimo Daltma last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 555-30 - 84 6. Sex 7. Age (In yrs. **Funeral** Min. 1 □ M 2 □ K Months Days Hours Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other treumstic event, the Madical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 Nes 2 No **Funeral Director** 1 timore 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent E Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ify only highest grade completed) dry (0-12) College (1-4or 5+) 17. Father's Name 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Nurial 2 ☐ Cremation 3 ☐ Removal from State 2403 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of trying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 PUMMIC **Physician** month /Medical Examiner ament Sequentially list conditions, if a y, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due o (or as x nsequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ W6 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 🗋 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient ٩ 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 5 Pending 1 TYes 2 □ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ted cause of death (Iter 23a) (Type, Print) 4940

State
 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Plea	se Type or Pri				Ensure A lealth and N			egible.	
		For State Registrar					rtificate of			Reg. No.	2008	
Physicia /Medic		1. Decedent's Name	e (First, Middl	Charles	Z		Lohoefer	III	2. Date of De Month July	Day	Year 2008	3. Time of Death 5:45 A M
Examine Funeral Director	er		ck Memo	n, give street and number Orial Hospit 6. Sex AMM 2□ F	al	<i>last birthday)</i> Yrs.	4b. City, Town, or Freder If Under 1 Year Months Days	ick If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De April			CK pplace (State or Foreign
yland Now		Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	cation	1				10d. Inside City Limits
the Mari	ector	MD 10e. Street and Nu	Carro	011	Wo	oodbin	e 10f. Zip Code			10a Citize	en of What Co	1 □ Yes 2124No
23a or	~ I	2605 Gill		ls Rd			21797			-	ed Stat	
rs a	۾	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		I If Yes Give	2 No	- 1	Was Decedent of H If Yes, specify Cuba 1 □ Yes → No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.
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Mental Mental arked o	To Be			hoefer, Jr			,	Mae Eliza	- 1			
nd 2 sho alth and 27 Is m		19a. Informant's N		ship (Type.Print) er (wife)				and Number or Ru alls Rd. V		-		(ip Code)
ges 1 ar If item or othe		20a. Method of Dis	position	3 ☐ Removal from State	3	lace of Dispo emetery, crer	sition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or	
mit. Pag bartmen bortant; Injury		4 ☐ Donation 21. Signature of Fu	5 Other (S	Specify)	Unio		pel Cem 2. Name and Addre	7/28/3 ess of Fa <u>ci</u> lity			rtytowr	
Per Jany		Just	Mi	ellen				ss of Facility en Funera l Liberty			d, MD 2	
Physician /Medical Examiner	_	shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on	r complications that cause only one cause on each a Due to (or a	s a consequ	ites	er the mode of dyll	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
our icia	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	5	c	DVT	dence of):						
The law requires that the death certificate bate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown	months?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal	Ideath 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	ey		2	3d. Date of del Month	ivery Day Year
res ti	ρ	Part II. Other signi	ficant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause giv	ven in Part I.				the cause of death?
n: The law re ficate has bee r, page 2 sho	Completed								24a. Was auto perfo 1 □ Yes	ormed?	24b. Were au prior to death? 1 □ Yes	utopsy findings available completion of cause of 2 ☐ No
ding Physician: The n	To Be	25. Was case refer examiner? 1 ☐ Yes 2 ☐	/	Hospital:	tient 2 🗆	ER/Outpatie	nt 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H	th <i>(Check only</i> ome 5 ☐ Res		☐Other (Spe	cify)
or Attending Physician: ifer death. Director: After this certifici	ation:	27. Manner of Deat 1 ☑ Natural 2 ☑ Accident	th 5 Pendin investi		jury Jay, Year)	28b. Time o Injury	Wor	ry at k?]Yes 2 □ No	28d. Describe	how injury	occurred	
al or Atte s after des I Directo d in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	nined 28e. Place of I	njury - At ho etc. (Specif		reet, factory, office			(Street and wn, State)		ural Route Number,
	Medical C	29a. Certifier (Check only one)	Certifyir 2☐ Medical	ng Physician: To the bes Examiner: On the basis and manner	of examina	wledge, deat tion and/or in	th occurred at the ti	ime, date and place opinion, death occu	e, and due to the irred at the time	e cause(s) , date and	and manner a place, and due	s stated. e to the cause(s)
To the within complete complet	M	29b. Signature and	tipe of certifie	er			29c. Licens	se number)	29d. Date	signed (Mont	h, Day, Year)
10		30. Name and addr	ress of person	who completed cause of	death (Item	23a) (Type,	Print)	1050, Rl		11-	t	
Stat Registra		31. Date filed (Mon	oth, Day, Year)	2 8 2008 32. Re	trar's Signa	ture	Soule	V-01/1-0				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month LITTLE **Physician** 22- 2008 GLADYS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner overlea Health and Baltimore If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1□ M 200 240-50-6817 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nature!" ~ " any injury or other treumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Ves 2 No MD Completed by Funeral Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 2402 W. Garrison Ave マロ15 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? ☐ Yes 2 ☐ No 1 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify: BIGC 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) somestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zeberdie. Burnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evans 19a. Informant's Name/Relationship (Type, Print) 805 Falconer Ad Joppa, MD Jean A. Martin 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burneys Chapel 7.04.46 Greene Funeral Services 22. Name and Address of Facility Vaugnn C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 4905 York Ad Baltimore, MD 212D rleno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Salval Decubit Wer. Stage-4 Due to (or as a consequence of): Physician/Medical Examiner Dementa Alzheimerstype Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Phy within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral!

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trai

5 Pending investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. KHAN 5601-Loch Raven Blvd Bulto MD 21239

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 0 8 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:53 A 24 2008 July Ann G. Largent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Manor Care - Potomac 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🗓 F 94 1913 Pennsylvania Director 187-36-4193 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exprimer must be notified at 10a State 10b. County 1 ☐ Yes 21 No Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20815 7115 Edgevale Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed wit tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, Ins. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Emma Bittner Albert D. Gomery ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 123 Orchard Drive, Apt. 11, Whitehall, PA 18052 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. once. Kathryn Stark/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 27, 1 ☐ Burlal 2 【Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2008 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. M01346 Bethesda, MD 20814 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054566 July 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli M.D. 9801 Georgia Avenue, Suite 1-17, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

JUL 28

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		Please T mend 19b, perFD G88 Amend 7 - State Registrar		Certific	ate of Death	2.	Re Date of Death	h		3. Time of Deat
Physicia		/					Month 0 7	24	Year O\$	9:26 P
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Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at once.	cto	MD NA		BALTIN	MRE					1X Yes 2□
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DHMH 17 Rev 1/2001

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10/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only	1 Certifyi 2 Medica	ng Physician: To I Examiner: On the	e basis o	f examina	owledge, dea	th occurre	d at the ti	me, date opinion, d	and place leath occu	and due to	the cause	(s) and m	anner as and due	stated. to the cause(s)	
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:46 PM 24,2008 SARAH E. MILLER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD CO BELAIR
If Under 1 Year | If Under 24 Hrs. UPPER CHESAPEAKE HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2006 MARYLAND 78 MAY 3 1930 212-28-3252 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2/XNo Director ABINGDON MARYLAND HARFORD CO 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21009 1116 BUSH RD Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: BLACK Specify. 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) iled within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) N/A HOUSEWIFE 11th grade permit. Pages 1 and 2 should be iled I Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic avent the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JANIE JOHNSON ပ RILEY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 539 Crownwood Ct., Edgewood, Maryland 21040 Valarina Higgins/Grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State COMMUNITY BAPTIST 08-02-08 JOPPA, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of une al Service Licensee 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown ed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signer should be d ģ 2 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 No 1 TYes Vital F monary 95 rdca 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Difficult Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053568 Bel Air Mary land 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) land 1 effrey

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 2 8 2008

moghbeli. m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. 45 JAWET V. WOGH 301, M.D. BAUTINME,

32. Registrar's Signature

JANET V. MOGHINELLIMO

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 48 M 2008 Margaret JULY 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memoria altimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ + Months Days Hours Min 423-20-1266 9 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits show 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Evar in an must be notified at 1 des 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the M-dical Eval: if not must bonce. 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TLNo Specify 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ortestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ Annie tu ller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eon G. Mank 1d Ave Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Daurial 2 ☐ Cremation 3 Removal from State 7.28.2008 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) s Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kughn C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death 4 DA45 **Physician** r neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ongested Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or s a consequence of): The law requires that the death certificate be executed use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No jo Year Month Day 5 ☐ Other (specify) P.0. the detached 9 Unknown signed by tage betached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy death? 1 ☐ Yes perform 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 M Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation neral Director; A 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

If we death occurred at the time, date and place, and due to the cause(s) and manner as stated.

If we death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 201 East University ENEI NOSUHOT 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ellx Moure 7 \mathcal{U}_{ℓ} 2008 /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Hours Min Director 30-1946 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Indical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 □ No Funeral Director ltimore 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College_(1-4or 5+) Ears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Nu Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition **⊠**Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) of Funeral Service Licensee a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cartinoma urynaeal disease or condition resulting in death) /Medical Due to (or as a or nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 1∐Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUITIV 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral Direc 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marine as some states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2: To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 060680 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)

HICHEUN FN MAIN STREET REISTON DWN, MN 21/36

Registrar

State

MICHEUPON

Year)

JUL 2 8 2008

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2008 **Physician** 5:20A M 22 MARGARET VOGEL July PERIN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A 1031 North Calvert Street Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Months Yrs 213-18-6062 95 June 26, 1913 Director Marvland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Directo Baltimore Maryland None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1031 North Calvert Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Swimming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter William Vogel Lillian May Kimpel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Neale Smith Jr Son 3117 Caves Road Owings Mills Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GreenMount Crematory July 24,2008 Baltimore, Maryland 5 ☐ Other (Specify) 4. □Donation gnature of Funer 22. Name and Address of Facily itchell-Wiedefeld Funeral Home Inc mus 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCIDENT CERROYAL VASCULAR Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩6 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifica 24 hours a To the within 2

Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HILAM DON M.D.

5901 North CHarles Street Baltimore Maryland 2. Registrar's Signature

and manner stated.

an mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

08-05397	
LINK HNK	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

U NK UN K			State of Maryland / Dep	artment of ertificate of			20 C	18 24178			
Physician		an/	Registrar 1. Decedent's Name (First, Middle,Last)	0	C D (8)	2. Date of Deat Month		3. Time of Death			
Madical Examine			TAWanna	PO	ag	July 14, 20	008	0723 hrs			
			4a. Facility Name (if not institution, give street and number) 601 Light Street	4	b: 🕪, Town, or Location Baltimore	of Death	. 4c. County of Deat				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)		der 24Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bit	thplace (State or Foreign			
	Director		216-540-5009 1 M 2 VF 58	Yrs	Months Days Hou		. 49	ountry) MD			
		ı	Usual Residence of Decedent			1001		11.2			
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director		y, Town or Locati				10d. Inside City Limits			
			MD NA B	altin	nore		1 Yes 2 No				
N			10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cou	intry?			
2			3115 Walbrook Avenue	a Lianu	21216	11-10/0 - 16-V No	U3/	siana Indian Black			
N			11. Marital Status 1 Never Married 2 Married Armed Forces?		s Decedent of Hispanic O es, specify Cuban, Mexica		White, etc.	rican Indian, Black,			
	fter de ", or er mu		3 Widowed 4 Divorced If Yes, Giva Year	1	Yes 2 No specif	fy:	Specify:	slack			
	5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner.		15. Decedent's Education (Specify only highest grade completed)		t's Usual Occupation (Giv		16b. Kind of Business	Industry			
			Elementary/Secondary (0-12) College (1-4 or 5+)	0	ost of working life. DO NO	of use retired)	100-5	m Company			
	within giene.	mo	12th Grade 2 years	Parc	alegal	er's Name (First, Middle, I		The Company			
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be C	17. Father's Name (First, Middle, Last) John Harford Poag, J.	r,	18.1001	lever	Reynol	ds i			
	212 ould bould by Ment mark	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and No	umber or Rural Route Nur	mber, City or lown, Stat	e, Zip Code) 2(2/6			
	MD d 2 sho lth and n 27 is numati		Clever Poag	311	5 Walbro	ok Avenue	Baltimore	MD			
	ore, I s I and of Healt If item		20a. Method of Disposition 20b 1 Burial 2 Cremation 3 Removal from State	 Place of Dispos crematory or ot 	ition (Name of cemetery, her place)	Date	20c. Location - City of	4 4 4			
	Page nent o		4 Donation 5 Other Specify:	Jetro (Crematory	0725-08	Baltimo	re, MD.			
	Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other ti Injury or other traumartic event, the Meg		21 Semalure of Funeral Service Licensee		Name and Address Faci	lity 2140 North	Fulton Aven	ve 21217			
			23a Part I Enter the disease or complications that caused the dea		seph H. Brou			Approximate Interval			
	Physician 'Medical		failure. List only one cause on each line. Between Onset at Death								
	xaminer	aminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
	. Sequentially list conditions,										
1	" . <u>.</u>	Unsues or highly that initiated C. Due to (or as a consequence of):									
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	30, e be ex ysician burial	edical	- ONF ENDED		TIM, GOOD		Loo L Data of delice	1			
	876 tificat	Σ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre		etal death 3 Ecto	pic pregnancy	23d. Date of delive Month	Day Year			
	Box 6876 he death certificate the attending phy hed for use as the beat the	sicia	past 12 months? 4 Pregnant at time of the past 12 months?	dooth	ther (Specify)						
	D. BC: the des	Phy	Part II. Other significant conditions contributing to death but not	t reculting in the	underlying cause given in	Port I 23e Did t	obacco use contribute t	o the cause of death?			
	P.O. Be sthat the d	δ	Take in other significant conditions	resolung in the	anderlying dabae given in			obably 4 Unknown			
	tal Records, P.C cian: The law requires that certificate has been signed ector, page 2 should be dete	ompleted				24a. Was	an 24b. Were	autopsy findings available			
	e law i	đ					ormed? death?				
	I Re	ပ	25. Was case referred to medical	,	26 Place of Dea	ith (Check only one)	2 No 1	Yes 2 No			
	/ita ysician nis cer directe	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien:	Other		Residence 6 🗸 Oth	er: Scene			
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury at Wo	ork? 28d. Describe	how injury occurred				
		at io	Natural 5 Pending Pending Fnd 7/14/0	8 unk	1 Yes 2	X No unk					
		ical Certification:	2 Accident and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
			Suicide A Could not be determined (Specify) water or Town, State) 4 Homicide determined (Specify) water 601 Light St. Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the Hospital within 24 hours To the Funeral completely filled		Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination								
	To t with To t	Medical	and manner stated. 29b Signature and title of certifier		29c. License numb		29d. Date signed (A				
			(V and balance)		O.C.M.E.		July 14, 2008				
	pt 1		30. Name and address of person who completed cause of death (Ite	em 23a)			J				
1	pera		Laron Locke MD. Assistant Medical Examine		Street, Baltimore,	MD 21201					
	91	ate	31. Date filed (Month, Day, Year)	ature Consu	(1)						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:30 AM 2008 Iamin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nion Memoria TIMORE Birthplace (State or Foreign Country) last birthday) 8. Date of Birth (Month, Day, 7. Age (In yrs. Security Number **Funeral** 1**X**M 2□ F Months Days Hours Min 224-22-1273 Director 1010 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other treumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ es 2 ☐ No Funeral Director 1 timore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 □Yes a No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. δ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sacondary (0-12) College (1-4or 5+) Beth leham 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Willie Brooks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nisbust enei 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important; if iter
eny Injury or ott 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 Removal from State 126/2008 Baltinory MD King Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe Sepsis 36 hrs Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Intravascular Coagulopath 24 hrs Disseminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Metabolic Acidosis 24 hrs Hospital or Attending Physician: The law requires that the death certificate be executed Gap Anton attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Veal 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 V No 1 ☐ Yes 3 Probably 4 Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospita or or within 24 hours after death.

To the Funeral Director: After momoletely filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number een, MD 2438946 July 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meegan C. Green, MD Union Memorial Hospital Baltimore, MD 21218

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 8 2008

DHMH 17 Rev 1/2001

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental Hygiene								01.100					
			State Registrar	Certificate of Death				Reg. No. 2008 24 80						
ı	Physici		1. Decedent's Name (First, Middle, Last)			eives				Date of Deat Month Suly	Day	Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			f Death	4c. County of Death				
Ч			The Johns Hopkins Ho	spital		Baltim						NA		
	Funeral Director		5. Social Security Number 6. Sec 1 5 1 5 - 28 - 9359	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, 12 - 2	Year)	9. Birthi Coun	place (State or Foreign try)	
	p ×	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation							I0d. Inside City Limits	
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	ter death wi items 23a ner must be	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13.	Vas Decede	nt of His	1	gin? (Specif	y Yes or No- an, etc.)	14	Race - Americ		
9		正	1 Never Married 2 Married	1 Yes 2 No			No	Specify:	, rueno mo	an, etc.)		Black, White, Specify:	eic.	
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12	within ene. than "	Ĕ	Elementary/Secondary (0-12)	College (1-4 or 5+)	\mathcal{J}_{n}	$m_{\rho} < 1$	100100)				Sple	C-em	ployed	
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Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is mark any injury or other traumatic once.		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address	Street a	nd Numbe	er or Rural I	Route Number	r, City or	Town, State, Zip	Code) 2/229	
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Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 6		ce of Dispo	sition (Name	e of er place)	Dat	е	20c. Loca	ation - City or To	own, State	
Ĕ	permit. Page Department of Important: If any injury of once.		4 Donation 5 Other (Specify)	Merrioval from State	T. Co	armel	Cer	n. (77-28	-08	Ba	HIMORE	MD	
alt	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	e	22	Name and	Addres	s of Facilit	×2140	North F	0/10		MD. 21217	
8	20 E P 9			y UW		oseph	14.		inur.	<i>Funer</i>		tome B	altimore	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	e cause on each line.	Do not ent	er the mode	of dying	g, such as	cardiac or i	respiratory arr	est,		Approximate Interval Between Onset and Death	
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687	certificate be iding physicia use as the bu	Med												
Box (n cert anding r use	an/	230. Was decedent pregnant	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d		Ectopic pre	ennancy				23	3d. Date of deliv		
	death e atte ed for	Sici	in the past 12 months? 1 ☐ Yes 2 🗓 No	4 Pregnant at time of deat		Other (spe						Month	Day Year	
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Vit	Physician: The this certificate are director, pa	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ☐ EF			Othe	٠.		Check only on			£.1	
of	Phys this ral d	6	1 Yes 2 No 27. Manner of Death	1 Minpatient 2 E	R/Outpatien 8b. Time o	-	c. Injury	4 LI NU		5 Resident		Other (Speci	y)	
on	nding Phy ath. :: After this	ţ	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	м	Work	? ⁄es 2 □	No					
Division of Vital Records,	Attend r death ctor: A	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At home	e, farm, str	eet, factory,	office		28			Number or Ru	al Route Number,	
Ö	s afte	Certification:	4 Nomicide	building, etc. (Specify)						City or Town	i, Siate)			
	To the Hospital or Attent within 24 hours after death To the Funeral Directors. completely filled in by the	Medical (sician: To the best of my knowle ner: On the basis of examinatio and manner stated.										
	To the within 2 to the comple	Ĭ Z	29b. Signature and title of certifier			29c.	License	number		2	29d. Date	signed (Month,	Day, Year)	
	->-0) Ith			1	KES	-00	0		Jul	y 21.	2008	
	3		30. Name and address of person who c	ompleted cause of death (Item 2	23a) (Type,	1			_			1 1)		
			Λ	ustan	. , , ,				600 N	orth Wo	lfe St	, Baltimo	re, MD, 21287	

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 18 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:35 P. M SARA LOUISE SIEBERT July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Broadmead Cockeysville
If Under 1 Year | If Under 24 Hrs. Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 7 F 88 1920 Maryland Director 214-40-6037 April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "necical Examiner is ust be notified at 1 ∐Yes 2 TNo Director Maryland Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? 21030 13801 York Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any Injury or other traumatic event, the Negones. Elementary/Secondary (0-12) College (1-4or 5+) 4 years Librarian Public Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ G. Siebert <u>Marguerite</u> Ebert Everett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hamill Road Suite 332 Baltimore, Maryland 21210 <u>Julian Lapides</u> (attorney) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 7-26-08 |Baltimore, Maryland Name and Address of Facility itchell-Wiedefeld Funeral Home, 5500 York Road Baltimore, Mary gnature of Funeral Ser 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ONGESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an age 2 s autopsy e 1 ☐ Yes 2 12 No this certification within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ M6 Be 26. Place of Death (Check only one) Hospital: Other: 4 Lursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Vem 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, State Registrar 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 24182 Certificate of Death 1. Deceden's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year 12:30 AM Seuari 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death laryland renero 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 1 2 F Months Days Hours Min. 215-46-8869 9 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Tes 2 □ No timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1100 Bolton St USA 21201 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 O 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 📉 0 Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surnaine) . Father's Name (First, Middle, Last) Slie 101 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6. MD 2/206 Ohonso 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service KRd. Balto Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Encephalopathy Due to (or as a consequence of): disease or condition resulting in death) Hepati Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). DQ D515

Examiner law requires that the death certificate be executed and the burial-trar Division of Vital Records, P.O. Box 68760, physician attending ph 24 hours after death.

• Funeral Director: After this certificate has been signed by the selective interior filled in by the funeral director, page 2 should be detached it. Hospital or Attending Physician: The

Examiner Physician/Medical Medical Certification: To Be Completed by within 24 hor To the Fune completely fi

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 2 8 2008

Physician

/Medical

Funeral Director

Be Completed by

٩

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment results to recitled at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

resulting in death) L	ast	d. Due to (or as a conseq		Foil	lure				
IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	il death 3 🗆 Ectopio				23d. Date of Month	delivery Day	Year
Part II. Other signifi	cant conditions or	ontributing to death but not res	ulting in the underlying	g cause give	n in Part I.		co use contribut		e of death?
				-		24a. Was an autopsy performe	prior deatl	to completion	
25. Was case referre	ed to medical				26. Place of De	ath (Check only one)			
examiner? 1 ☐ Yes 2	No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 □	DOA Othe	r: 4 🗆 Nursing	Home 5 ☐ Residence	e 6 □Other (5	Specify)	
27. Manner of Death 1 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work' 1 □ Y	at es 2 □No	28d. Describe how	injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office		28f. Location (Stree City or Town, S	et and Number o State)	r Rural Route	Number,
	1 Dertifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurrent ation and/or investigati	ed at the tim on, in my op	e, date and placinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manne and place, and	er as stated. due to the ca	use(s)

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

2

127-1

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008^{e ar} JULY **Physician** 24 **SCHERR** MORRIS /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner TOWSON GILCHRIST HOSPICE CARE Date of Birth (Month, Day, Year) 12/19/1931 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 76 Director 213-28-7401 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Mydical Exactions and injury or other traumatic event, its Mydical Exactions and be notified at once. 10a, State 10b. County **Funeral Director** MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 14 BARDEEN COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHERR ANNÁ SAMUEL ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 EAST MAIN STREET, EMMITSBURG, MD 21727 MISSY SCHERR-PHILLIPS/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 Removal from State BETH TFILOH CONG. 07/25/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility ignature of neral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ations that caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** ymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Nam Physician/Medical Examiner be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 4 24 08 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes Morris To the Hospital or Attending Physiclan: The law i within 24 hours after death. To the Funeral Director: After this certificate has bi 24a. Was an page 2 autopsy director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27, Manner of eath 28b. Time of 28c. Injury at Work?

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

11:05A

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 No

BALTIMORE

USA

WHITE

HOSPITAL

Approximate

years

Interval Between Onset and Death

GOLDBERG

13 State Registrar

n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur

completely

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

Year)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

f=certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

United ST POWSON NO 21204

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Physician /Medical

or Attending Physicien: The law requires that the death certificate be executed anding physician and use as the burial-tran P.O. Box 68760, Division of Vital Records. After this r death. ours after death.

neral Director: A
filled in by the fu

July 24, Day 2008 7:30 AM Thomas Patrick Toomey 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Lighthouse Assisted Living Essex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months Days Hours 73 098-26-4413 Director 07/26/1934 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, In "Michael Eventine" is used the millibed at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Maryland Baltimore Rosedale 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral 21237 U.S.A. 5174 Brightleaf Court 12. Was Decedent Ever in U.S. Armed Forces? 1 图 es 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Firefighter NYC Fire Department 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Helen O'Halloran ပ Thomas Toomev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5174 Brightleaf Court, Baltimore, Maryland 21237 C.Patricia Toomey (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 07/25/2008 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 112 remer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 1 € 5 Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) heldan Kurun m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9110 Phylas helda Milher 31. Date filed (Month, Day, Year) 32_Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () () 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ZZ: 48 PM 24 2008 July ernando /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center
5. Social Security Number | 6. Sex | 7. Age (In vrs. last Baltimore Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□F 522-40-6636 72 July 24, 1936 Colorado Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 214 Carroll Rd. 21060 United States Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Spanish 1⊠Yes 2□No "natural", or Specify. þ Year or Dates: 154-157 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other traumatic event, the Medical Once. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isaias Vigil Elvera Sanchez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna M. Vigil / Wife 214 Carroll Rd., Geln Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 29, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Cedar Hill Cemetery Brooklyn Park, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Signa (re of A neral S Vice Licen) ee 3/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idio athic Pa Physician Palmonary One year /Medical **Examiner** Two weeks Pneumrnia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2□1 2□No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month)

29b. Signature and title of certifier

Greene

South

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simcex

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, MD ZIZOI

			1 - For State Registrer	te of Maryla		artment of F		and Mer		ien 200	8	24187
	Physici	20	1. Decedent's Name (First, Middle, Last)					2.	Date of Death		ear .	3. Time of Death
	/Medic		Thelma Y. Warren					15 11	JUly		008	- 7-10P.M
	Examir	er	4a. Facility Name (If not institution, give street a.	nd number)	AL	4b. City, Town, o	LTI	mo	RE	4c. County of	Death	
	Funeral Director		5. Social Security Number 6. Sex 1		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min. J	Date of Birth (Month, Day, June 28	Year) , 1912	Countr	ace (State or Foreign ry) yland
	pu *		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	cation					10	d. Inside City Limits
	Aaryla f ehor	ō		100.		sville						1 ☐ Yes 2 🔼 No
	1 28a-	Directo	Maryland Baltimore 10e. Street and Number		Caton	10f. Zip Code			10	0g. Citizen of Wh	at Count	ry?
	th with		1003 Woodsdale Road			212	28			USA		
	er dea	Funeral	Am	s Decedent Ever in led Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Orig an, Mexican	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race - Black,	America White, e	
	36 urs afte	by F	If Y	Yes 2⊠No es, Give irorDates:		1 ☐ Yes 2🎦 No	Specity:			Specify:	Whi	te
	5-00	eted	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Deced	dent's Usual Occup	ation during most	t of working		16b. Kind of Busi	ness/Ind	ustry
	within ne.	Completed	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	Cle	kind of work done DO NOT use retire	d)	3		US Gove	rnme	nt
	d 2 filed v there		12 17. Father's Name (First, Middle, Last)		CIE	! LK	18. Mothe	ar's Name (F	<u>-</u>	Maiden Sumame)		
	lanuld be Aental	To Be	Unknown				Uı	nknowr	n			
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Service of the result of th		19a. Informant's Name/Relationship (Type, Prin			ng Address (Street						
	e, Not the alth		Richard McQuay Fri 20a. Method of Disposition			Woodsda		ad; Ca		20c. Location - C		
	nor ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I IIOIII State		sition (Name of matory or other pla	-	7-26-		Baltimor		
	mit. P partme portan / injur		21. Signature of Funeral Service Licenses	WV		Name and Addre uneral Ho	ss of Facilit	y Ster	ling As	shton Sc	hwab	Witzke
	W 49 F 4 8		Clysakell	Alen	2 1	uneral Ho 630 Edmor	ome or idson	Avenu	nsville e; Cato	e, inc. onsville	, MD	21228
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus immediate Cause (Final disease or condition resulting in death)	that caused the de e on each line.		er the mode of dyn					2	Approximate Interval Between Onset and Death Unknown
ø	(a) 15	Iner	cause. Enter Underlying	ue to (or as a cons	equence of):							
Ě	3760, ate be executed hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events c c	ue to (or as a cons	equence of):							
6	760 te be e	cai	d									
T	c 68		IF FEMALE:									
11	cords, P.O. Box 68 w requires that the death certificate been signed by the attending preshould be detached for use as the	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	es, outcome of preg Live birth 2 Tee Pregnant at time of Unknown	etal death 3]Ectopic pregnanc] Other (s <i>pecify)</i> _	ey are			23d. Date Mont		ny Day Year
arre	Records, P.O. The law requires that the ten has been signed by the page 2 should be detached.	by	Part II. Other significant conditions contributir	ig to death but not r	esulting in the u	nderlying cause gr	ven in Part I				oute to th	ne cause of death? abiy 4 nknown
3	Re la he la ge 2 age 2	Completed		=					24a. Was a autops perform	sy pr med ₂ de	ior to con	psy findings available appletion of cause of
	of Vital Physician: rthis certifica	Be	25. Was case referred to medical examiner? Hospital		./	G . Ott	ham		Check only of			
	9 Physer this	n: To	27. Manner of leath 28a	1 ☐ Inpatient 2 Date of Injury (Month, Day Year)		IL 3LI DUA	4 🗆 190			ence 6 Other		"
	ath.	atio	2 Accident investigation	(Month, Day Year)	Injury		nk?]Yes 2□	No				
	Division of Vital pital or Attending Physician: Tours after death. Theral Director: After this certificat filled in by the tuneral director, pa	Certification;	3 Suicide 6 Could not be determined 28e	Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		28	f. Location (S City or Town	treet and Numbe n, State)	r or Rura	l Route Number,
	Division of To the Hospital or Attending Plantin 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	edical C	29a. Certifier 12 Certifying Physician: (Check only one) 14 Certifying Physician: 2 Medical Examiner: Or an									
	To the within To the comp	Me	29b. Signature and title of certifier	1992	0	29c. Licen		etom-suv		29d. Date signed	9	1.25
	,		20 Not Player	un M	2221 77	Point)	00550	549	ı	TUly 23	200	08
	6		30. Name and address of person who complete	Agner H	1909, (Type,	900 C	ton A	Lome	-130/hi	nove M	ory 6	ant
	Sta Regist		31. Date filed (Month, Day, Year) JUL 28 2008	32 Aegistrar's Sig	B. Bo	والأنا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Welborn Μ. Mary 07 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Owings Mills 22 Pickersgill Square If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 217-32-7817 Yrs **Director** 12 20 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: If item 27 Is marked other than "natural", or items 23a or 28a-f show up or other traumatic event, in a Medical Expression 1, use the rediffice at 10a, State 10c. City, Town or Location Director Owings Mills MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21117 Funeral 22 Pickersgill Square 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No ı ∐Yes 2∭No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify Completed by 3√ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Coleman Squire Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Pickersgill Square, Owings Mills, Md 21117 Ruth Allen-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. King Memorial Park 7/28/08 4 Donation 5 ☐ Other (Specify) Woodlawn, 21. Signatule of Funeral Service Ligensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear in literature. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a nonsequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 2 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes Division of Vital Records, P.O. ignificant conditions contributing to death but for resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 2 X No 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 **13** No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home X No 1□ Yes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident within 24 hours after deatl To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

5 Residence 6 ☐ Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Year

4:20p.

MD

1 □Yes 2√□No

10d. Inside City Limits

Birthplace (State or Foreign Country)

Black

21215

Approximate Interval Between Oriset and Death

Day

3 Probably 4 Unknown

2 No

Year

State Registrar 29a. Certifier

29b. Signature and

31. Date filed (Month, Day, Year)

itle of certifier

30. Name and address of person who completed cause

Medical

28a) (Type, Print)

32. Registrar's Signature

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:40 AM Alexander nciron 08 06 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER Georges CreekRd 12230 Frostburg Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Maryland **Funeral** 214-46-3644 1 □ M 2 7 F Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the literature. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frostburg Allegany 1 ☐ Yes 2 No MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532-12230 Upper Georges Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No PV Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Cliff DO NOT use retired) Elemany/Secondary (0-12) 1 College (1-4or 5+) Hospital 17. Father's Name (First, Middle, Last)
James "Butch" Speir 18. Mother's Name (First, Middle, Maiden Surname)

Margaret Speir Be ۵ 19a. Informant's Name/Relationship (Type. Print)

Thomas F. Alexander, Husband bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12230 Upper Georges Ck Frostburg Maryland 21532-20b. Place of Disposition (Name of 20c. Location - City or Town, State
Frostburg Maryland 20a. Method of Disposition July 02, 2008 1 N Burial 2 □ Cremation 3 □ Removal from State Frostourg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lim only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hyperbilirubemia
Due to (or as a consequence of): /Medical Examiner Endometrial Carcinoma metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Metastasis rain and physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Metastasis to spine Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Compression 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy s certificate ha death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No မှ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and till 29c. License number 29d. Date signed (Month, Day, Year) 00066439 6 301 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRs Cumborland, MD 2150 Blanche 904 Seton Drive H. Marromatis 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 25, 2008 10:08 A Ella Mae Arnold June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-Frostburg Nursing & Rehab Center Allegany If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Maryland Director 214-05-4451 October 20, 1916 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Examiner must be notified at 1 **⊈**Yes 2 □ No Director Allegany Frostburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 260 W. Mechanic Street U.S.A. 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>^</u> White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown state university or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louisa Bachman Charles E. Danner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry McKenzie 21532-Department of Health Important: if item 27 Maryland daughter 20000 National Highway Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 28, 2008 Frostburg Memorial Park Frostburg Maryland injury o 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee è Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovasular 6months Atherosolerotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical SS IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 menths? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknowr signed by 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an To the Funeral Director: After this certificate has 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes 2 ER/Outpatient 4 Nursing Home 3□ DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24

State

Registrar

WONSOCK SHIN 31. Date filed (Month, Day, Year) JUN 2 7 2008

29b. Signature and title of certifier

925 BISHOP Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd Cumberland Mp 21502 Walsh

29c. License number

00055325

29d. Date signed (Month, Day, Year)

June 25, 2008

			for Stata Registrar	State o	f Marylar	•	artment of H		Mental Hy	giene Reg. No.	800	24191
ı	Physici	an	1. Decedent's Name (First, Middle,	*					2. Date of De	eath Day	Year	3. Time of Death
ı	/Medic		Gabriela M. Arro						July 1	0, 200		12:55 A ^M
	Examin	er	4a. Facility Name (If not institution,		mber)		4b. City, Town, or		ath		ounty of Deatl	
	Funeral		10301 Gainsborou 5. Social Security Number 6	gn Koad	7. Age (In yrs.	last birthday)	Potoma If Under 1 Year		rs. 8. Date of Bi	rth	ntgome:	ry hplace (State or Foreign
	Director		577-62-1896	1□M 2☑F	91	Yrs.	Months Days	Hours Mi	Mar. 1	7, Year)	Co.	untry)
	p a		Usual Residence of Decedent 10a. State 10b. County		10a Cii	ty, Town or Lo	estion					10d. Inside City Limits
	Aaryla I sho	ō				•						1⊠Yes 2□No
	the h	Director	DC None		Wa	shingt	On 10f. Zip Code			10g. Citize	n of What Co	untry?
	3a or	D	3900 Watson Plac	e. NW #3	B Bldg.	В	20016			U.S	. A .	,
	hours after death with the Maryland tural', or Itams 23a or 28e-f show at Exertiral rout be rotified at	Funeral	11. Marital Status		edent Ever in U	I.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No		. Race - Ame Black, White	
ð	or Ita		1 Never Married 2 Marrie	d 1 □ Yes If Yes, Giv	2 ☑ No ve		1 ☐ Yes 2 ☒ No	Specify:	nto mount, ote.,	s	pecify: Wh	
315-UU36	hours tural'	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or D	ates:	16a Dagge	dent's Usual Occupa	ntion			of Business/	
ÿ	nin 72 n "na n "vezilo	Completed	(Specify only highest	grade completed)	1.4005.)	(Give	kind of work done of DO NOT use retired	durina most of w	vorking	TOD. KING	oi business/	industry
717	d with giene er the	mo	Elementary/Secondary (0-12)	College (1 5-	,	Rea1	Estate			Assoc	iate B	roker
land	al Hy d othe	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's N	ame (First, Middle	, Maiden Si	ımame)	
<u> Yaa</u>	ould I Ment warks	P	Enrique Menendez			-		Maria				
Mar	d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship				ng Address (Street a					Zip Code)
o L	1 and Healt Iem 2		Nicolas E. Arroy 20a. Method of Disposition	o – Son	20b. F	Place of Dispo	Sangamore sition (Name of		Date	_	20816 tion - City or	Town, State
ē	Pages ant of nt; If it		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		natory`or other plac		11/2000			
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event. The Medical Examinat must be notified at anone.		21. Signature of Funeral Service Li		Mat		Crematory Name and Address Ward Sage	s of Facility	11/2000	rall	s Chur	ch, Virginia
ă	P C E E		Oonald (State	Tems	res 10	ward Sage	ille Pik	cal Direc ce Rocky	tion,	MD 20	852
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that c	aused the at	th. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. AS	FIRAT	DUN	PNEU	MONIA				Onset and Death 2 WK5
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	quence of):						
		-	Sequentially list conditions, if any, leading to immediate		or as a conseq							$\sim 1 \text{ yr}$
	uted J ansit	Examiner	Cause (Disease or injury that initiated events		,	, , , , , , , , , , , , , , , , , , , ,						
ĵ	exectant and rial-Ira	Exa	resulting in death) Last	c. Due to	(or as a conseq	quence of):						***************************************
8/00,	icate be executed physician and s the burial-Iransit	dicai		d								
٥		Med	IF FEMALE:								-	
OO	death certif e attending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	come of pregna orth 2 Peta	al death 3	Ectopic pregnancy			23	 d. Date of deli Month 	ivery Day Year
	The de	Physician/Me	1 □ Yes 2 🖼 No 9 □ Unknown	9□ Unkno	ant at time of down	ieath 5∟	Other (specify)					
7.	The law requires that the death certif tle has been signed by the attending page 2 should be detached for use a	by Pr	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
cords,	quire an sig uld b								1 🗆	Yes 2 🔀	No 3□Pr	obabiy 4 Unknown
) 1)	law re	ompleted							24a. Was		24b. Were au	itopsy findings available completion of cause of
ב ב	The ate he	Сош							perf 1 ☐ Yes	ormed?	death?	2 No
<u> </u>	ician: artific actor,	Be	25. Was case referred to medical examiner?	11					eath (Check only			A-4
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5	ding h. After funer	tion	1 Natural 5 Pending		th, Day Year)	28b. Time of Injury	Work	/at ⟨? Yes 2 □ No	200. Describe	now injury o	xccurred	
DIVISION	Attan deat actor: by the	ifica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, office				Number or Ru	ural Route Number,
5	s afte	Certification:	4 Homicide	buildi	ng, etc. (Specil	(y)			City or To	wn, State)		
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2.	edical (29a. Certifier 1 Certifying (Check only one)	caminer: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	n occurred at the tim vestigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) a , date and p	nd manner as lace, and due	s stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and man	- Statos.		29c. License	number		29d. Date	signed (Monti	h, Day, Year)
. 1	5		MINAY	8			D_	1787	4	7.	10-2	800
-			30. Name and address of person w	to completed caus	se of death (Item	m 23a) (Type,	Print)		CITY	MD	207	22_
	Sta Registr		31. Date filed (Month, Day, Year) JUL 14	108	3717 - legistrar's Signa	ature dos	with I					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** 4:32 P. M JULY 7, 2008 MARY JANE BARLOCK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 □ M 2 🕱 F Yrs JUNE 30, 1943 MARYLAND 65 212-42-0506 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2X No Directo MARYLAND ANNE ARUNDEL SEVERNA PARK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 UNITED STATES 3 BELLEVIEW DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) The Porces? ☐Yes 2 X No Yes, Give 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Ş Q 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SOCIAL SECURITY ADMINISTRATION Elementary/Secondary (0-12) College (1-4or 5+) SYSTEMS ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES GERKIN LOUISE DERRINGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 BELLEVIEW DRIVE, SEVERNA PARK, MARYLAND 21146 TINA M. MORRIS/DAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a Method of Disposition CHESAPEARE CREMATION JULY 10, CENTER 2008 STEVENSVILLE, MARYLAND 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & CREMATION AND FUNERAL CARE, P.A., 814 ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Lices M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on expline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a second conditions, if a second conditions are considered as a second condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions of the conditions, if the conditions, if the conditions of Due to or as a conse uence of Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 30 2 No 1 🗆 Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manger of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed and burial-tran Box 68760, attending physician the asn for 1 signed by the a P.O. cate has been si page 2 should b certificate this

funeral director, After death.

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Mactical Examinacing the notified at

within 72 hours after

s 1 and 2 should be filed w f Health and Mental Hygie Item 27 is marked other ti

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permit. Pages 1 a
Department of He
Important: If item
any injury or othe

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Records, Division of Vital To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date 29b. Signature ar e of certifie

signed (Month, Day, Year)

ath (Item 23a) (Type, Print) 30. Name and address of

RD300 AMMAPOUS

Year) 31. Date filed (Month, Day, JUL

4 Homicide

29a. Certifier

one)

Medical

Amended Part II, nls, per phy., 07/09/08, Allegany Co. 1 - State Registrar Physician /Medical Examiner Funeral Director 10a. State Director PA Funeral ð Completed Be P

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 12:58 AM 150 B15V 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Months Days Hours 85 286-16-3297 4-26-1923 PΔ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Warfordsburg Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1871 Black Oak Rd 17267 USA Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Butcher Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Bishop Mary Ellen Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David L. Bishop/ Son 1871 Black Oak Rd Warfordsburg, PA 17267 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Johnstown Crematory 7-9-2008 Johnstown FA 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licenses Home Inc 169 Clarence ST Hyndman PA 15545 23a. Part 1. Enter the disease or com shock, or heart failure. List only r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ordiovasa **Physician** /Medical Due to (or as a consequence of): **Examiner** Louis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗽 Unknown Be Completed Osteoporotic Fracture 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No funeral director, page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) / and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 3 TT 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 1110 Medical Campus Rd. MAS JUL 0 9 2008 State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of H			iene g. No. 20	08	241	94
			Decedent's Name (First, Middle, Last,)				2. Date of Deat Month		Year	3. Time of De	eath
	Physici /Medi	_	Patrick	St	ephen	Boyle		June 2'	7, 2008	rear	1824	M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	1	4c. County	of Death		
			WMHS-Braddock Car	mpus			berland				gany	
	Funeral		Social Security Number 6. Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	9. Birthpl Count	ace (State or F ry)	-oreign
н	Director		212-30-5242	XM 2LIF 6	8 Yrs.			03/23/19	940	Mary	land	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10	d. Inside City	Limits
	Aaryli f sho ed at	ŏ	MD Allegar	nv	1	Mt. Savag	0				1 ☐ Yes 2	! □XNo
	the N 28a-	Director	10e. Street and Number	119	-	10f. Zip Code		11	Og. Citizen of W	/hat Count	try?	
	with with the same	Ö	12715 Periwink	kle Lane			545		II	SA		
	72 hours after death with the Maryland hatural", or Items 23a or 28a-f show disal Examiner must be notifled at	by Funeral	,	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race	- America		
9	after or Itel	Ρ̈́	1 ☐ Never Married 2 🎇 Married	Armed Forces? 1 X Yes 2 ☐ No	1963-			to Hican, etc.)		k, White, e	etc.	
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5-0	72 hc natu dical	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup	during most of wo	rking I	16b. Kind of Bu	siness/Ind	ustry	
2121	ithin ne. an "	현	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retired	,		Poil	.road		
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and	12 should be filed within 7. h and Mental Hygiene. 7 is marked other than "n traumatic event, the Medi	To Be (17. Father's Name (First, Middle, Last) Patrick Steph	nen Svl	vester	Boyle	Anna	ne <i>(First, Middle, I</i> l Berna	adina		ahame	
3	nould d Mer narke	မ				ng Address (Street						
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Ty Katherine Boyle	,		5 Periwin				. ,	545	
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و	nt of In It it		1 K Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or other plac				•		
Baltimore,	it. P.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			ick's Cem 2. Name and Addre		0/2008	Mt. Sa	_ ,		ΡΔ
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	k 9	21. Signature of Pulleral Service Licens	Idams		404 Decat			•		1502 Approximate	
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ā			25. Was case referred to medical						-A	1 □ Yes	2□ No	
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0	⊑	5	27. Manner of Death	1 ☐ Inpatien	28b. Time o	1 0 DOX	4 Li Nursing	Home 5 ☐ Reside			<i>y)</i>	
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_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co		rsician: To the best of iner: On the basis of	examination and/or in							
	ithin (Mec	29b. Signature and little of certifier	and manner stat	ou.	29c. Licens	se number	2	29d. Date signe	d (Month.	Day, Year)	
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	8+		20 Nama and address of	omploted agus of t	ath (Ham Oan) (Tur-		09157		June	<u>-1,</u>	2000	
	TARS		30. Name and address of person who of Paul Snow, M		West Thir		Cumberl	and, MD	21502			
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	Regist		31. Date filed (Month, Day, Year) JUN 3 0 2	008	r's Signature	goode						

			For State Registrar	State of Ma	-	partment of te partificate of		d Mental Hyg ı	-	108 21	.195
	Physici /Medic	_	Decedent's Name (First, Middle, L OLIVER			BOLDEN		2. Date of Dea Month 07	Day	Year 8 0700	of Death M
	Examir		4a. Facility Name (If not institution, g			4b. City, Town,		Death	4c. County		
1		186	WMHS BRADDOCK C		a /la um laat hirthdr	CUMBERI		Hrs. 8. Date of Birt		LEGANY 9. Birthplace (State	or Foreign
ľ	Funeral Director		5. Social Security Number 6. 212-24-2156	Sex 7. Ag	e (In yrs. last birthda 80 Yrs.	Months Days		Min. (Month, Da	y, Year) 01, 1928	Country) Maryland	or Foreign
	TO		Usual Residence of Decedent								
	anylan show dat	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside (es 2 No
	the Mi 28a-f	Director	Maryland Garre		Finzel	10f. Zip Code			10g. Citizen of V		
	with with the r	١	222 Fig	zel Road		21532-			U.S.A.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 Nowled 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			oan, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac	e - American Indian, ck, White, etc.	
9	2 hour atural cal Ex	ted t	15. Decedent's	Education	16a. De	cedent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry	
21215-0036	within 7; iene. than "n he Medi	omplei	(Specify only highest g	College (1-4or 5	14.1	ve kind of work done DO NOT use retire usion departm		t working	fiber mar	nufacturer	
Maryland 2	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, La. Arthur Bolden	st)				Name (First, Middle,	Maiden Surnan	ne)	
ary	shoul	T ₀	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (Stree		or Rural Route Numb	er, City or Town,	State, Zip Code)	
	and 2 salth a		Denise Eckhart	daughter	156	6 National Hig	hway (Cumberland	Mary	land 2150)2
Baltimore,	Pages 1 into the page of He It it item ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control o		cemetery, o	position (Name of rematory or other pla cl Cemetery	ace)	Date July 11, 2008	20c. Location -	City or Town, State Maryland	
Balti	permit. Departm Importal any Inju		21. Signature of Funeral Service Lic	ensee		22. Name and Addr		57 Frost Ave.	, Frostburg	, MD 21532	
4	Physician /Medical Examiner	Examiner	23a. P. Enter the disease, or co cock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, language. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence of):		ng, such as ca	Ui	rrest,	Approxim Interval B Onset an	Between d Death
. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су			te of delivery	Year
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	by	9 ☐ Unknown Part II. Other significant conditions		Phase Me	underlying cause g	iven in Part I.	23e. Did t	Yes 2□No	tribute to the cause of	Unknown
al Re	sician: The law scertificate has t irector, page 2 s	Completed						auto	psy ormed?	prior to completion o death? 1 ☐ Yes 2 ☐ No	f cause of
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ō	ing Phys h. After this (funeral dir	- T	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ent 2 ☐ ER/Outpa ury 28b. Tim	IEIII 3 DOA		ing Home 5 ☐ Resi	how injury occur		
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	Natural 5	(Month, Da		y M 1	∃Yes 2∐No	28f, Location (ber or Rural Route N	umber,
	ie Hospita 124 hours ie Funeral letely filled	Medical C	29a. Certifier (Check only one) Certifying Certifying Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination and/o	eath occurred at the r investigation, in my	time, date and opinion, death	place, and due to the occurred at the time	cause(s) and m , date and place,	anner as stated. and due to the caus	e(s)
	To the He within 24 To the Fi	Me	29b. Signature and title of certifier	.1		29c. Licer	nse number		29d. Date signe	ed (Month, Day, Year)
	7		Cer por	7 /	4.0.	000	63368	?	07/	08/2008	3
	how		30. Name and address of person who Doth HY ut	completed cause of o	death (Item 23a) (Ty			mberland	MP2	1502	
	Sta	ite	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	arte		1 - 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GROVE OCKVI HOSP c mer HADY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Min. 931 INDIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ir than "natural", or items 23a or 28a-f show 1 Yes 2 No DAMASCUS Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 1 15A 404 ascus Lery, 208 TRYIC 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Asian Specify: 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Market Elementary/Secondary (0-12) College (1-4or 5+) Indian settlement ommissioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) [V102c/7] 19a. Informant's Name/Relationship (Type. Print) RASHI 2 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State nlko Takistan 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility den AS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minuto **Physician** Juneardia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 -Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 32 registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medica 32 Degistrar's Signature

		For State Registrar		State of Ma	-	epartme <i>Certifica</i>			vieritai my	rgiene Reg. No. 2	กกล	24198
Phys	sician	1. Decedent's Name (*					2. Date of D Month	eath Day	Year	3. Time of Death 3:01 PM
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. In "exical Early injury or other traumatic event."	by Funeral Director	507 MAII 11. Marital Status 1 □ Never Married 3 🕱 Widowed 4	d 2□ Married	12. Was Decedent Armed Forces? 1 XYes 2	•	13. Was Dec If Yes, sp 1 □ Yes	edent of Hi ecify Cuba	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	lo- 14. R	D STAT ace - Americ ack, White, e	an Indian, etc.
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nd 2 should alth and Me 27 Is mark	٩	19a. Informant's Nam	ne/Relationship	(Type. Print)		-		and Number or Ru	ıral Route Num	ber, City or Tow	n, State, Zip	
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HX X)	30. Name and address		completed cause of	death (Item 23a) (Type, Print)	. (Palati		Cu. F 11	n A	anyolis Mo

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 22, **Physician** 2008 12:25 PMM Mary Cook /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Health Care Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 29, 1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Canada 1 ☐ M 21 F 220-28-3749 80 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28e-f ehow the Medical Examinar must be notified at Yes 2 No Maryland Frederick Frederick Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 489 East Church Street 21701 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a any injury or other treumatic event, tra Medical Exercises 2008. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 9 Waitress/Barmaid Food Service 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Delaney Mary Boland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Terry L. Cook, son 1014 Mercer Place, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State Smithsburg Crematory July 23, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure to Thrive Months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien end the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, pege 2 should be 1 Yes 2 No 3 Probably WUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 Yes 2 No 2 Accident investigation hours after deat in 24 hour.
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'v filled in by th 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062223 July 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Praveen Bolarum, M.D., 196 Thomas Johnson Drive, Suite 230, Frederick, MD 21702

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 2 8 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 2

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F rtificate of I	lealth and N Death		giene 2 Reg. No.	2008	24200
Physi		1. Decedent's Name (First, Middle, L Elizabeth Via					2. Date of Dea Month July	22 Day	2008°	3. Time of Death 8:55 A. M
/Med Exam		4a. Facility Name (If not institution, g	ive street and number)			Location of Death		4c. C	ounty of Death	1
Funera		Northampton Mane 5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	Freder If Under 1 Year		8. Date of Birt	h	Freder:	polace (State or Foreign
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ath with t 23a or 2 ust be n	ral Dir	10e. Street and Number 6632 Jefferson	Blvd.		10f. Zip Code 21	714	1		en of What Cou ed Stat	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Eva Libration at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ଐNo	ispanic Origin? (Span, Mexican, Puerto Specify:	oecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
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lanc lid be fi Mental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Las Frank Elmore V				18. Mother's Nam Julia	e Harris		urname)	
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Baltii permit. F Departm Importar any Injur		21. Signature of Funeral Service Lice	ensee	22	2. Name and Addres	ss of Facility Kee	eney & P	asfor	rd Fune	ral Home
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Box 6 leath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7 5 atomic manage			23	3d. Date of deli	ivery
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Divis	Certification: T	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, stro y)	eet, factory, office		28f. Location (S City or Tov	Street and vn, State)	Number or Ru	iral Route Number,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificic completely filled in by the funeral director,	Medical (29a. Certifier Certifying F	Physician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deati tion and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
To th Withir To th	Me	29b. Signatule and title of certifier		el.	29c. Licens	e number	2	29d. Date	signed (Month	h, Day, Year)
		30. Name and address of person who	-71	^	Print)	, ,	·	1/2	2/08	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 9, 4:50 A ^M 2008 Alice K. Eiss /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F 23, 1923 Virginia 85 **Director** 579-22-8602 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the "Matcal Expression of the Institute at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Funeral Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 U.S.A. 2116 Coleridge Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha (Unknown) ဂ Morris Kershenbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan R. Eiss - Daughter 9210 Adelaide Drive Bethesda, MD 20817 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns. 7/13/08 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
2001 Rockville Pike Rockville, MD 20852 Jonald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMON **Physician** /Medical Due to (or as a consequence of): Examiner MONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off the Hospital or Attending Physician: The law requires that the death certificate be executed MONARY sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria HYPOXEMIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Munpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ္ရ 08 D65953 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD 20910 Adaku Onukogu, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 14 Registrar

		•	For State Registrar	Oldio Ol I	viai y iai ic	•	rtificate of		_	Reg. No.	2008	24202
-2	Physicia		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	_		Ruth Anr		dis			July	12,	2008	8: 22 a ^M
The same	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, o			4c.	County of Death Ceo	
			100 Greenway, A 5. Social Security Number 6.		U2 Age (In yrs. la	et hirthday)	If Under 1 Year	rryville	rs. 8 Date of Bi	rth		
Н	Funeral Director		219-16-8132	1 M 2 K F	Age (III yis. ia 82	Yrs.	Months Days	Hours Mi		av, Year) 5 . 19	26 M	place (State or Foreign ntry) aryland
Δ.	.2	ŀ	Usual Residence of Decedent									aryrana
	yland now at		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	a-f sl	ctor	Maryland Cec	il			Pe	rryville				1 X Yes 2 No
	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	-
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Completed by Funeral Director	100 Greenway, A					21903			U.S.A	
	er de	nue	11. Marital Status	12. Was Decede Armed Force	s?	3. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Netro Rican, etc.)	0-	 Race - Ameri Black, White 	
36	s afte	Ϋ́	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 21 If Yes, Give Year or Date			1 ☐ Yes 2 🖾 No	Specify:			Specify: W	nite
9	hour Itural	ed t	15. Decedent's			16a. Dece	dent's Usual Occu	pation		16b. Kit	nd of Business/li	ndustry
15	in 72 n "na Aedic	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4d	7. E. \	(Give	kind of work done DO NOT use retire	during most of v d)	vorking			
21215-0036	should be filed with nd Mental Hygiene, marked other that matic event, the M	E	Twelve Years	College (1-40	JI 5+)		Homemak	er		Pe	rsonal :	Residence
	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La.	st)	-			18. Mother's N	łame (First, Middle	e, Maiden	Surname)	
Maryland	uld by Menta rrked rtic e	70	Alonzo	Reynolds	Gille	spie			Mary L	etici	a Geisl	er
an	2 sho and I is ma		19a. Informant's Name/Relationship				ng Address (Street					
	and and n 27		David G. Fotiadi	s (son)) Forest					
ore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from Sta	ate 20b. Pl	ace of Disp emetery, cre	osition (Name of matory or other pla		Date		cation - City or 1	
Ë	Pag ment tant: lury o		4 □ Donation 5 □ Other (Spec	cify)	Но	-	.1 Cemete	-	7/15/08	1		t, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign whre of Funeral Service Lic	ense	m.A		2. Name and Addre					, P.A.
	100		23a. Part1. Enter the disease, or co	mplications that cau	sed the death	-	Perryvill ter the mode of dy			1903- arrest,	0766	Approximate Interval Between
3	Dissertation	S 5	shock, or heart failure. List on Immediate Cause (Final	ly one caus n eac	h line.	0	ter	10 -				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a conse	ence of):		Lliste				1912
	Examiner											
		ner	Sequentially list conditions,	Due to or	as a consequ	ence of						
	cuted nd ransii	ami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
0,	e exe ian al ırial-t	Ë	resulting in death) Last	Due to (or	as a consequ	ence of):						
68760,	tificate be executed ig physician and as the burial-transit	ledical Examiner		d								
	± on a		IF FEMALE:	000 16								
Box	death cert e attending d for use a	Physician//	23b. Was decedent pregnant in the past 12 months?		h 2□Fetal	death 3	□Ectopic pregnan	У			23d. Date of deli Month	very Day Year
o.		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Pregnar 9⊟Unknow	nt at time of de n	еатп 5	Other (specify)					
Δ.	requires that the de sen signed by the a rould be detached	, Ph	Part II. Other significant conditions	contributing to deat	hyøut not resu	Ilting in the	underlying cause gi	ven in Part I.	23e. Dio	l tobacco i	use contribute to	the cause of death?
Records,	w requires been signe should be	Completed by	(andion	yo pall	ng .				1	Yes 2	□ No 3 □ Pr	obably 4 Munknown
Ö	> 9 5	lete	Da lite	8hel	Vi tu	2 TI			24a. Wa	is an	24b. Were au	topsy findings available
Re	e la has le 2	m d	1/4 00 /2						— aut	topsy rformed?	prior to death?	completion of cause of
Vital	i cian: Th certificate rector, pag		25. Was case reled to medical	men				26 Place of	1 Yes Death (Check only	2 🔀 No	1 □Yes	2 □ No
>	Physician: this certific al director,	o Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2 🗆	EB/Outnatie	ent 3 DOA Of	hor:	ng Home 5 🖺 Re		6 □Other (Soe	cify)
0		n: To	27. Manner of Death	28a. Date of	Injury	28b. Time	of 28c. Inju		28d. Describ			5.177
0	Attending death.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury		Yes 2 No				
Division	r Atte er deg recto by th	tific	3 Suicide 6 Could not 4 Homicide determine	Zoe. Flace U	f injury - At ho	me, farm, s	treet, factory, office		28f. Location City or 7	(Street ar	nd Number or Ri	ural Route Number,
Ö	Ital or rs afte ral Dir led in	Certification:										
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ical	(Check only 2 Medical Ex	Physician: To the b aminer: On the bas	is of examina							
	thin 2 the I	Medical	29b. Signature and the of certifier	and manne	r stated.		29c Licer	se number		29d Da	ite signed (Moni	h. Dav. Year)
	To To To To		255. Signature and rule of certifier		M.P.			1599	4		-15 -	
					2 2 L 1 T 7		1-11	/	/		1 -	

DHMH 17 Rev 1/2001

State Registrar Leticia S. Galvez, M.D., 625 South Union Avenue, Havre de Grace, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUL 1 5 2008

24

08-05005 Willis Ervin Hardr	nan	Please Ty , Jr	rpe or Print in State of Marylar	Black Ind nd / Depa	<mark>delib</mark> rtme	le Ink. En	sure All C	opies Are Leg tal Hygiene		08 2420
		- For State Registrar	-	Cer	tificat	te of Death		Reg	J. No.	00 2420
Physicial Medical Examin	n/ er	1. Decedent's Name (First, Mid Willis	Erv			Hardma		June 28, 20	Day Year)08	3. Time of Death 2130 hrs
1		4a. Facility Name (if not institut Memorial Hospital				Cumbe			Allegany	
Funeral Director		5. Social Security Number 217-90-6145 Usual Residence of Decedent	6. Sex 7	7. Age (In yrs. Ia	ist birtho	Months Yrs.		24Hrs. 8. Date of Birth Min. 04 / 18 /		rthplace (State or ign Maryland ountry)
d how any.	Ī	10a. State 10b. Count	y llegany	10c. City,		·Location Cumberla	nd		-	10d. Inside City Limits 1 Yes 2 XNo
the Marylan or 28a-fs	Director	10e. Street and Number 14525 Har		L		10f. Zip (21502	10	g. Citizen of What Co USA	untry?
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at once.	Funeral		Married Armed For	dent Ever in U. rces? 2 X No	S.	If Yes, specify	Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	White, etc.	rican Indian, Black,
tours after	호.	15. Decedent's Education (Sp			16a. D		X No specify: occupation (Give ing life, DO NOT	kind of work done	Specify: 16b. Kind of Busines:	White White
21215-0036 ould be filed within 721 Mental Hygiene. s marked other than ", ic event, the Medical E.	Completed	Elementary/Secondary (0-12		4 or 5+)		Mainten		r's Name (First, Middle, N	Dai	ry
215-(be filed on that Hyg rked oth	Bec	17. Father's Name (First, Midd Willis	e, Last) Ervin	ŀ	lard	man, Sr.				ewis
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene, tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.		19a. Informant's Name/Relatio Casey L. Hard		iter				mber or Rural Route Num e, Cumberlai		
nore, Nages Land at of Health	Ī	20a. Method of Disposition 1 X Burial 2 Cremati		m State	cremato	Disposition (Namery or other place) nt Grove		Date 07/02/2008	20c. Location - City Cumberl	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is m injury or other traumatic.		4 Donation 5 Other 21. Annature of Funeral Servi	Specify: ce Licensee	,				treet, Cumb		1 Home, F.A. 21502
Physician Miedical raminer		23a Part Enter the disease, failure. List only one cau Immediate Cause (Final disea	se on each line.			enter the mode o	f dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
(animer	-	or condition resulting in death	Due to (or as a	consequence c	of):	- Di				
	<u>,</u>	Sequentially list conditions, if any, leading to immediate	b. Atherosclere Due to (or as a			ar Disease		-		
	amine	cause. Enter Underlying Cause (Disease or injury that initiated	se c							
executed an and al - transit	al Exa	events resulting in death) Las	d.	consequence o	of):					
1 m m 6		UNPENDED	AMENDED			.			23d. Date of deliv	1000
Records, P.O. Box 68760, The law requires that the death certificate be execute cate has been signed by the attending physician and page 2 should be detached for use as the burial - trait		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	1 Live bi	ant at time of de	2	=		ic pregnancy	Month	Day Year
P.O. E es that the igned by the be detached	<u>a</u>	Part II. Other significant con	ditions contributing to	death but not	resulting	in the underlying	cause given in F			to the cause of death?
of Vital Records, P.O. of Pysician: The law requires that the three this certificate has been signed by meral director, page 2 should be detach	Completed					 	·		osy prior ormed? death	
		25. Was case referred to med	ical				26.Place of Deat	h (Check only one)	2 No 1 🗸	res 2 no
Vita hysician this cer	o Be	examiner?	11-11-11-1	npatient 2	ER/O		OA Other	Nursing Home 5	Residence 6 O	ther:
ion of \ itending Ph. leath. tor: After tl		27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. T	ime of Injury	28c. Injury at Wo		how injury occurred	
Division spital or Attendii hours after death. uneral Director: /	Certification:	2 Accident In 3 Suicide 6 C	vestigation	e of Injury - At I	nome, fa	rm, street, factory				Rural Route Number, City
Hospi 24 hou Funer tely fil	Medical Ce	4 Homicide 29a. Certifier 1 Certifying one) 2 Medical E	Physic n: To the besixa ner:On the basis of	of examination	dge, dea and/or ir	ith occurred at the	time, date and p	place, and due to the cau occurred at the time, date	se(s) and manner as	stated. o the cause(s)
S T vit	Mec	29b. Signature and title of cer	lifier and manner s	tated.		29	c. License numbe	er	29d. Date signed	
nks		30. Name and add of of per	on who completed caus	se of death (Ite	m 23a)		O.C.M.E.		June 29, 2008	,
OCME		Mary G. Repple MD.	Deputy Chief I	Medical Exa	miner		Street, Balti	more, MD 21201		
St. Regist	ate rar	31. Date filed (Month, Day, Ye JUN 3 0	2008	egistrar's Sign	19	parte			···	

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		1	For State Registrar	State of Ma		epartment of F Certificate of		⁄Iental Hygi ¤	ene g. No. 20	08	24205
2	Physicia	_	1. Decedent's Name (First, Middle,	•	1	IIh a.u.t a.o.		2. Date of Death Month	n Day	Year	3. Time of Death
	/Medic	al	Mary 4a. Facility Name (If not institution,	Kath.		Humbertson	or Location of Death	July 7	2008 4c. County of	of Death	2:16 A
ř.	Examin	er	WMHS-Memoria				berland				egany
	Funeral			6. Sex 7. Ag 1 ☐ M 2 💢 F	e (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Countr	*/
	Director		215-26-6328 Usual Residence of Decedent		81 Y	10.		03/05/1	927	Mary]	land
	yland how at		10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Mar Ba-f sl	Director		egany		Oldtown		1	0g. Citizen of W	/hat Count	
	with the	Dire	10e. Street and Number		a.P.	10f. Zip Code		'	og. Oilizell of W		· y ·
	ns 23 must	Funeral	11. Marital Status	ertson Lane,	Ever in U.S.	215 13. Was Decedent of I if Yes, specify Cub		pecify Yes or No-		USA e - America k, White, e	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:		1 ☐ Yes 2☐ No		o mean, etc.)	Specify	: Wh	ite
5-0	72 ho 'natur dical I	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	16a. l	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	king	16b. Kind of Bu	siness/Indi	ustry
121	within ene. than '	dm	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homemal	•		Hom	_	
	Hygi Hygi Int, t		17. Father's Name (First, Middle, I	ast)		пошешая		ne (First, Middle, i		_	
Maryland	2 should be f and Mental H is marked of raumatic ever	To Be	Romanus	Joseph		mstetter	Clar			eck	
lary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationsh			Mailing Address (Stree					
	1 and 2 Health tem 27 i		Frank R. Humber 20a. Method of Disposition	tson / Son		401 Humbers Disposition (Name of y, crematory or other place)		, SE, O1	dtown, 20c. Location -		2.1555 wn, State
or O			1 X Bunal 2 ☐ Cremation			y, crematory or other pla Memorial I	1	10/2008	Cumban	land	MD
Baltimore,	+ E 22 = -		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service		Sunset	22. Name and Addr	ress of Facility A	dams Fam	lly Fur	neral	Home, P.A.
Ba	permi Depar Impor any ir		PROLLY X	adam	6	404 Decat				1D 2	1502
	Physician		23a. PartT. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		d the death. Do n ine.	ot enter the mode of dy	ring, such as cardia	c or respiratory ari	rest,		Approximate Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as	a consequence of		_ 85				
	Lammer	<u>~</u>	Sequentially list conditions,		inated I	ntravascula :n:	ar Coagula	ation			
	ured Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in doubth) as the conditions of the conditions of the conditions of the conditions of the cause of	`	ranial B	•					
oʻ	te be executed ysician and e burial-transit	Examiner	resulting in death) Last	`	a consequence	of):					
3760,	ate be nysicie he bul	ca		d. Hypoka	lemia						
O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)				ate of deliver	ery Day Year
Records, P.O.	requires that the death een signed by the atten rould be detached for u	Completed by Ph	Part II. Other significant condition Acute Renal F		but not resulting ir	the underlying cause of	given in Part I.				he cause of death? pably 4 쩟Unknown
OS	s beer shou	olete	Anemia					24a. Was		Were auto	ppsy findings available impletion of cause of
R	sician: The law certificate has t irector, page 2 s	mo	Hypercalcemia					perfo	rmed? 2 X No	death? 1 ☐ Yes	2□ No
/ita	cian: ertifica ector, I		25. Was case referred to medica examiner?	Henrital				eath (Check only o	ne		
or	Physic this c	To Be	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 X Inpat		tpatient 3 DOA		Home 5 ☐ Resident Re			fy)
ono	ding h. h. After funer	tion:	1 Natural 5 Pendir 2 Accident investi	g (Month, D	ay Year)	njury W	lork? □Yes 2□No				
Division or Vital	or Attending fter death. birector: After n by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of in	njury - At home, fa etc. <i>(Specify)</i>	rm, street, factory, offic	ee	28f. Location (: City or To	Street and Num vn, State)	ber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical Ce	29a. Certifier 1 X Certifyin (Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner s	of examination ar	e, death occurred at the nd/or investigation, in m	e time, date and place by opinion, death oc	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as s , and due i	stated. to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifie	· 0	MI	1.	ense number		29d. Date sign		
	3		1 Josu	forka	1		0066070		July	7, 2	800
	nes		30. Name and address of person Madhusudhan	Tarigopula	, M.D.,	900 Seton	Drive, Cu	umberland	d, MD	21502	
	St Regist	ate rar	31. Date filed (Month, Day, Year,	2. Regis	strar's Signature	prese					

2008

5:25A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐XYes 2 ☐ No

Maryland

White

29d. Date signed (Month, Day, Year)

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not enter the mode of dying, such as cardiane cause on each line.	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	DETSPITATOS FAI	14. =	2 01
Examiner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of):	n-y Emboli	2 weeky
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	23d. Date of d Month	lelivery Day Year
eted by Pr	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ② Yes 2 □ No 3 □ 24a. Was an 24b. Were	Probably 4 ☐ Unknown
Compl			autopsy prior t	autopsy findings available o completion of cause of ? es 2 \(\square\) No
Be	25. Was case referred to medical examiner?		ath (Check only one)	
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	Home 5₽ Residence 6 ☐ Other (S)	pecify)
ation:	27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
edical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
edical		rsiclan: To the best of my knowledge, death occurred at the time, date and placiner: On the basis of examination and/or investigation, in my opinion, death occand manner stated.		

29c. License number

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

50

of person who completed cause of death (Item 23a) (Type, Print) 70364

32 Registrar's Signature

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/	Lt.	/	и	1
	7	-	$\mathbf{\circ}$	- 0

Physician
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		Registrar		Cert	lificate of i	Jeam	R	eg. No.				
/sicia	n	1. Decedent's Name (First, Middle, Last)					Date of Dear Month	Dav	Year	3. Time of Death		
ledica		Shirley Cecel		т			July	18	2008	6:27P		
amine	er	4a. Facility Name (If not institution, give street				Location of Death			ounty of Death			
-0		Golden Living Cente 5. Social Security Number 6. Sex	7. Age (In yrs. last	hirthday	Westmi	nster If Under 24 Hrs.	8 Date of Birth		rroll	place (State or Forei		
eral		5. Social Security Number 6. Sex 1		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) Aug. 21	Year)	Coui	yland		
ctor	-	Usual Residence of Decedent	09				Aug. Zi	, ,	JU Hai	yrana		
18		10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limi		
De la	호	Maryland Carroll			New V	Vindsor				1⊠Yes 2□N		
rugt	Director	10e. Street and Number			10f. Zip Code		1	I0g. Citize	n of What Cou	ntry?		
81 25		1260 Coe Drive				21776	į		U.S.A.			
any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Vas Decedent Ever in U.S.	13. W	as Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Ameri Black, White,			
E I		1 ☐ Never Married 2 ☐ Married 1	□Yes 2 X No Yes, Give		□Yes 2 📉 No			S	pecify: DI			
2	d by		ear or Dates:	0- D	antia Unual Canus	otion		teh Kind	D I of Business/In	ack		
Folice	Completed	15. Decedent's Education (Specify only highest grade con		(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of work	ing	TOD. KING	Of Dusiness/ii	idusti y		
9	E .	Elementary/Secondary (0-12)	College (1-4or 5+)	me. D	domestic	ate hom	nes					
aut,	ပ္	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,					
S e v	o Be	John Edward Star	r Coffman			Mary I	Emma Joh	nson				
E	욘	19a. Informant's Name/Relationship (Type. F		19b. Mailing	Address (Street	and Number or Rur			Town, State, Zi	ip Code)		
		Clarence G. Hill/ hu	sband	P.O.	Box 196	New W	indsor,	MD 2	1776			
		20a. Method of Disposition	20h Plac	e of Dispos	ition (Name of atory or other place		Date		ation - City or T	own, State		
y o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State			i i	1/2008	Syke	sville.	MD		
e u	}	4 Donation 5 Other (Specify) All County Cremation 7/24/2008 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHartzler Funeral Home										
ā		(atharina). Y	Jarker			ch St.			r, MD 2	1776		
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car								Approximate Interval Between		
ian		Immediate Cause (Final disease or condition	ANPOLOCA	CIAC	ma of	Lung U	with be	244	metrhs	Onset and Death		
cal		Immediate Cause (Final disease or condition resulting in death) a. A CAZUNCNA OF WING WITH BRAY MEWING Onset and Due to (or as a consequence of):										
ner		Discovery and the state of the										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
2	Examiner	Cause (Disease or injury that initiated events c.										
5												
	dica	d						<u> </u>				
3	n/Medical	IF FEMALE:	f yes, outcome of pregnanc	v				0.0	المام المام			
	ian	in the past 12-months?	1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregnan	СУ		23d. Date of delivery Month Day Year				
	ysic		4 ☐ Pregnant at time of dea 9 ☐ Unknown	ui əL	Other (specify) _							
	by Physicia	Part II. Other significant conditions contribu	uting to death but not resulting	ven in Part I.	in Part I. 23e. Did tobacco use contribute to the cause of death?							
2	b o						120	/es 2 □	No 3∐ Pro	obably 4 🗆 Unkno		
completely lineu ili by the laneta unector, page 2 should be detached for use as the bullarit ansi	Completed						24a. Was	an	24b. Were aut	topsy findings availa		
D D	dm						autop	rmed/2	prior to d death?	completion of cause		
1		OF Was soon referred to medical				00 Pl/ D	1 ☐ Yes	2 No	1 □ Yes	2 □ No		
	Be	25. Was case referred to medical examiner?	ital: 4 🗆 Innational 2 🗆 🗆	2/Outnation	· all pox Oti	26. Place of Dear	ome 5 ☐ Resid		Other (Cnee	alful		
	Certification: To	1 Yes 2 No 1 No 27 Manner of Death 2	8a. Date of Injury 28	Bb. Time of	t 3 ☐ DOA ☐	ry at	28d. Describe I			31ly)		
	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wo	rḱ?]Yes 2 ☐ No						
	fica	3 ☐ Suicide 6 ☐ Could not be 2	8e. Place of Injury - At home	e, farm, stre	eet, factory, office		28f. Location (S	Street and	Number or Ru	ural Route Number,		
Ц	erti	4 Homicide determined building, etc. (Specify)										
		29a. Certifier 1 Certifying Physicia	n: To the best of my knowle	edge, death	occurred at the	ime, date and place	, and due to the	cause(s)	and manner as	s stated.		
	Medical	(Check only 2 Medical Examiner: one)	On the basis of examinatio and manner stated.	n and/or in	vestigation, in my	opinion, death occu	rred at the time,					
	Ĭ	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	signed (Month	h, Day, Year)		
		1 Thish C	Jalu w		73	1660		07	1212	008		
		30. Name and address of person who compl			Print)	1660 oner Au	(2)	1 100	ar Min	vstea		
		THOMAS K. G.	ALVIN MO	9	al ST	once Au	thue	We	SI KALL	mornited		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e des								
istra	ar	1111 2 8 2008	Marina A	100								

08-05270 Jun Boo Kwon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate c			Reg.	No. 00	00 0100
Physicia	an/	Decedent's Name (First, Middle,Las					2. Date of Death Month	ay Year	0817 hrs
Medical Exami		Jun Boo 4a. Facility Name (if not institution, give	Kwon		4b. City, Town, or	Location of Deat	July 9, 2008	4c. County of Dea	
		Howard County General F			Columbia	Eccation of Death		Howard	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Yea		_		Birthplace (State or Foreign Country)
Director		214-96-8647	KM 2 F	55 _Y	Months Day	rs Hours Mir	June 2		uth Korea
		Usual Residence of Decedent							10d. Inside City Limits
w any		10a. State 10b. County MD Montgome		y, Town or Loca Silver					1 X Yes 2 No
daryland 28a-f show d at nice	후	MD Montgome	ery .	olivei	10f. Zip Code		1100	. Citizen of What Co	
e Mar or 28s	Director	2716 Sheraton	Street		20906	i		South Kor	· 1
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at ance		11. Marital Status	12. Was Decedent Ever in		/as Decedent of Hi	spanic Origin? (S			erican Indian, Black,
r item	Funeral	1 Never Married 2XX Married	Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	White, etc.	
after (by F		If Yes, Give Yeer or Dates:		Yes 2 _X No			Specify: As	
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examir	eq	15. Decedent's Education (Specify of			ent's Usual Occupa most of working life			6b. Kind of Busines	s/Industry
36 nin 72 Linan e	B	Elementary/Secondary (0-12)	College (1-4 or 5+)	Pa	inter			Private	
5-003 Hed withi Hygiene. d other th	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Ki Yong Kwon				Un Nyei			
D 21 should and Me 7 is ma	유	19a. Informant's Name/Relationship (,			er, City or Town, Sta	
e, MD I and 2 sho Health and item 27 is		Jung M. Kwon - N			osition (Name of ce			ring, MD 20c. Location - City	
Baltimore, MD 2 sernit. Pages I and 2 shou Department of Health and Important: If item 27 is in		1 Burial 2 X Cremation 3	Removal from State	crematory or	other place)			•	
timent rtment y or o		4 Donation 5 Other Specify 21. Sign by of Funeral Service Lice	<u> </u>	-	Name and Addres			Beltsvil	
Baltimore permit. Pages I Department of H Important: If i injury or other	: 1)	* Vur.			. reallo and real oc	D		Pl., Lort	uary Service
Physician		23a. Partil. Enter the disease, or com	plications that caused the dea	th. Do not ente	r the mode of dying	, such as cardiac	or respiratory arres	it, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		failure. List only one cause on e Immediate Cause (Final disease a	Atherosclerotic Cardic	vascular D	isease				Death
LXdiffile		or condition resulting in death)	Due to (or as a consequence	of):					
`-	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
h	Examiner	(Disease or injury that initiated	Due to (or as a consequence	of):					
recuted and transit		events resulting in death) Last		01).					
a a a	Medical	UNPENDED	AMENDED						
760, icate be ex physiciar the burial	Me.	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Date of deliv	
ox 687 eath certific	ian	past 12 months?	1 Live birth Pregnant at time of	J 4L	Fetal death 3 Other (Specify)	Ectopic preg	nancy	Month	Day Year
Box 68 e death certiff the attending ed for use as	Physician	1 Yes 2 No 9 Unknow		3	Other (Specify)				
P.O. es that the gned by t		Part II. Other significant conditions	contributing to death but no	t resulting in the	e underlying cause	given in Part I.			to the cause of death?
S, P nires th	ed by								Probably 4 Unknown
ords, P	Completed						24a. Was a autops	y prior	a autopsy findings available to completion of cause of
Recc The lar cate ha	ĕ						perform 1 Yes 2	n <u>ed</u> ? death ✓ No 1	Yes 2 No
Vital Rec ysician: The I his certificate I	Be	25. Was case referred to medical examiner?	Hospital:			Other Nurs			
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should t	ျ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie		jury at Work?		Residence 6 Of	ther:
n of \ nding Phy th. :: After the	ion:	1 ✓ Natural 5 Pending	(Month, Day, Year)	Zob. Time C	· · ·	Yes 2 No	200. 5003.25	,,	
Division rs after death. al Director: A	ficat	2 Accident Investiga	28e Place of Injury - At	home, farm, st	reet, factory, office	building, etc.			Rural Route Number, City
Divi pital or ours afte	Certification:	3 Suicide 6 Could no determine					or Town, St	ate)	
the Hospita hin 24 hours the Funeral		29a. Certifier 1 Certifying Physic	cian: To the best of my knowle	edge, death oc	curred at the time,	date and place, a	nd due to the cause	e(s) and manner as s	stated.
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	- 40	er:On the basis of examination and manner stated.	and/or investi			at the time, date a		
2	Σ	29b. Signature and title of certifier	$(l, \alpha, 0)$	d . ~	107	se number		29d. Date signed (July 9, 2008	моптп, рау, үеаг)
		Caral 1	talla		0.0	/.IVI.L.		July 0, 2000	
		30. Name and address of person who Carol Allan, MD Assist	completed cause of death (Ite ant Medical Examiner		n Street, Baltir	more, MD 212	201		
<u></u>	tate	31 Date filed (Month Days Veer)	32 Registrar's Sign		- M				
Regis	trar	JOL TO SO	08 Bleeve	OF ANN	BACC!				<u></u>

DHMH 17 Rev 1/2001 OCME 2006

	1 - Stete Registrar			Certifica	ate of	Death		Reg	. No. 2	IN 8	2421	79
	1. Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day	Year	3. Time of Deat	h
	JAMES LEWIS	LEASE						ULY	3, 2	800	8:30 P.	М
	4a. Facility Name (If not institution, give s 15009 LILLIAN		S.W.			r Location of RLAND			4c. County ALL	of Death		
	Social Security Number 6. Sex	7. Ag	e (In yrs. last birt		der 1 Year	If Under 24	4 Hrs. 8.	Date of Birth (Month, Day,)	(ear)	9. Birth	hplace (State or For	eign
l	-217-30-1896	M 2□F	77	Yrs. Month	ns Days	Hours	AU	īg. 20,	1930	MA	RYLAND	
H	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location							10d. Inside City Lin	nits
	MD ALLEGA	αv	CTIMB:	ERLAND							1 □ Yes 2 🔀	No
	10e. Street and Number	4.1			Zip Code			10	g. Citizen of	What Co	untry?	
	15009 LILLIAN AVI	ENTIF. S.V	J_		21502	2			U.S.A			
-		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was De		lispanic Origi an, Mexican,	in? (Specify	/ Yes or No-		ce - Amer	rican Indian,	
	1 ☐ Never Married 2 ☐ Married	1 Yes 2	No		2 X No	Specify:	r dello nio	an, etc.)				
L	3 X Widowed 4 □ Divorced	Year or Dates:	191-161						Specif	441	HITE	
	15. Decedent's Educ (Specify only highest grade		16a.	Decedent's U	work done	during most a	of working	1	6b. Kind of B	usiness/	Industry	
ľ	Elementary/Secondary (0-12)	College (1-4or	5+)	MEAT (RETA	IL G	ROCERY	
ŀ	17. Father's Name (First, Middle, Last)		L				's Name (F	irst, Middle, M	aiden Surnar	ne)		
	SAMUEL LOUIS LEAS	SE						Y McKEI				
H	19a, Informant's Name/Relationship (Typ		19b	. Mailing Addr	ess (Street	and Number	or Rural R	loute Number,	City or Town	State, 2	Zip Code)	
	ANDREW L. LEASE	/ SON	1	5009 L	ILLIA	N DRIV	E, S.	W., CUI	MBERLA	ND,	MD 21502	2
2	Oa. Method of Disposition		cemete	Disposition (I	Name of	ce)	Date	2	0c. Location	- City or	Town, State	
	1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	SUNSET			1	/08/2	8008	CUMB	ERLA	ND, MD	
r	21. Signature of Funeral Service License	e ,	4.	22. Name	and Addre	ss of Facility	,	HOME, P	7.			
	(400 md P). Ly	Ochule						CUMBE:		MD	21502	
:	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that cause ne cause on each l	d the death. Do ine.	not enter the n	node of dyi	ng, such as c	cardiac or re	espiretory erre	st,		Approximate Interval Between	1
1	Immediate Cause (Final disease or condition	Cere	sei nam	(له مي	L	inf					Onset and Death	-
r	resulting in death)	Due to (or as	a consequence	of):		8						
,	Sequentially list conditions, fany, leading to immediate)		-6.								
(C	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	OT}:								
th	hat initiated events esulting in death) Last	Due to /or as	a consequence	of):								
		Due to (or as	00004461106	/-								
		l										
	F FEMALE: 2	3c. If yes, outcome							23d. D	ate of de	livery	
'	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 Fetal death	3 □Ectopi 5 □ Other	c pregnanc (specify)_	y				onth	Day Year	
L	9 Unknown	9□Unknown										
P	Part II. Other significant conditions cor	ntributing to death	out not resulting in	the underlyin	ng cause gi	veп in Part I.		23e. Did tob	acco use cor	ntribute to	o the cause of death	1?
								y k Ye	s 2 No	3 🗆 P	robably 4 □Unkr	iown
								24a. Was ar	24b	. Were a	utopsy findings avai	lable
-								autopsy perform	/	prior to death?	completion of cause s 2 No	101
	25. Was case referred to medical					26. Place	of Death (Check only one			20.10	
2	examiner? 1 ☐ Yes 2 No	lospital: 1 ☐ Inpat	ient 2 ☐ ER/Ou	ıtpatient 3□	DOA Ot	her:	rsing Home	•	nce 6 🗆 O	ther (Spe	ecify)	
		28a. Date of Inj		Time of njury	28c. Inju	iry at	28	d. Describe ho				
		(Month D	ay / ca//									
L	Natural 5 ☐ Pending investigation	(Month, D	ay rear)	M	1 [Yes 2 N	No					
	Natural 5 ☐ Pending	(Month, D	ijury - At home, fa	М				f. Location (Str City or Town	reet and Nun , State)	ber or R	lural Route Number,	
L	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of in building, e	jury - At home, fa	M rm, street, fac	ctory, office		28	City or Town	, State)	_		
	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could more be	28e. Place of ir building, e	jury - At home, fa totc. (Specify) t of my knowledg of examination ar	M nrm, street, fac e, death occur	ctory, office	ime, date an	28 d place, an	City or Town	, State) ause(s) and n	nanner a	as stated.	

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

29c. License number

Dou 33280

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

Suni Gupta, M., 31. Date filed (Month, Day, Year) Kent Avenue,
32. Registrar's Signature Cumberland, MD 21502 625

JUL 0 8 2008

9+

MAS

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Stephen Walter Lodowski 11, 7:20 a July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ kM 2 □ F Director 212-82-0831 45 1963 Maryland Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heathh and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantuar must be mailined at Funeral Director 1 ☐ Yes 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13118 Ardennes Avenue 20851 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1x Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Musician Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth N. Lodowski Paula Keane ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Lautzenheiser/Mother 7216 Neuman Street, Springfield, VA 22150 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or or 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State July 16 2008 Lakemont Memorial 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, Maryland Garden Same and Address of Facility 21. Signature of Figheral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Man 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Carcinoma of Unknown Primary Source resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bilateral Malignant Pleural Effusions Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation

Box 68760. P.O. Division of Vital Records,

Certification: To

Hospital or Attending PhysIclan: The law requires that the death certificate be executed after death in by the 24 hours a

Medical

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

3 🗍 Suicide

29a. Certifier

within 2 To the 1

State Registrar

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria K. D'Arbella, MD

6 ☐ Could not be

29c. License number D62520

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

July 11, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1500 Forest Glen Road, Silver Spring, MD 20910

. Registrar's Signature JUL 14 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:06 PM 07, 2008 Ju1y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□F Feb. 22, 1956 52 China Director 578-19-4661 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2K No Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be 1. 20876 China 21111 Tulip Poplar Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yi Mei Chen Ji Xin Liu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21111 Tulip Poplar Way, Germantown, MD 20876 Department of Health Important: If item 27 any Injury or other to Hong Dai / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Ft. Lincoln Crematory 7/14/2008 4 □ Donation 5 □ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enterine disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or con **on **Physician** Hepatocellular Carcinoma disease or con resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical attending | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No ed by the 9□Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 No 1 🙀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: I Director: After this id in by the funeral d To the Hospital within 24 hours a To the Funeral I ompletely filled

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madan Bangalore, M.D. 31. Date filed (Month, Day, Year)

JUL 14

2008

Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

29c. License number

D0067512

29d. Date signed (Month, Day, Year)

July 7, 2008

State Registrar

Medical

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08-05097 Akili Odell McShan

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	Examir		4a. Facility Name (If not institution, give	street and number)		46	c. City, Tow	m, or Location of D	eath		4c. County	of Death	1
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	Funeral		5. Social Security Number 6. Sec	Ma alle	e (In yrs. las	M	Under 1 Ye onths Da		Hrs. 8	Date of Birth (Month, Day	21,193	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent		71	Yrs.			M	arcn A	21,193	/	PA
	/land		10a. State 10b. County		10c. City,	Town or Location	on						10d. Inside City Limits
	Mary In sh	to	MD Cecil		Co	nowing	oro						1 ☐ Yes 🏋 No
	death with the Maryland ms 23a or 28a-f show Embst be routflad at	Director	10e. Street and Number				10f. Zip Cod	de			10g. Citizen of V	What Cou	intry?
	23a c	alD	1670 Liberty	Grove F	Rd.		21	1918			U	.S.	Α
) 0	or dea	Funeral	The trial tale of the tale of	12. Was Decedent I Armed Forces?		13. Was	Decedent s, specify (of Hispanic Origin' Cuban, Mexican, P	? (Speci uerto Ri	fy Yes or No- can, etc.)	14. Rac Blac	e - Amer ck, White	ican Indian, , etc.
0015	s ofte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates;	1957	10	Yes 🏖	No Specify:			Specify	v: W1	nite
00/	2 hou	edi	15. Decedent's Edu		1961	16a. Decedent	's Usual Od	ccupation			16b. Kind of Br		
215	hin 77	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5		(Give kind	d of work do NOT use re	one during most of	working	,			
	d wit	Completed	12	-		Bi	inder				Pub	lis	ning
12/08	be file d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden Suman	10)	
> = = = = = = = = = = = = = = = = = = =	ould Men narke	ဥ	No Information		able					Macila			
/2/ Mary	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (T) Ronn Lacovara/B.		1	-		reet and Number o dgewood					ip Code) 08201
	1 and Heelt em 2		20a. Method of Disposition	rocher	20b. Pla	ce of Disposition			A V G	-	20c. Location -		
7 Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Deparment of Heelih and Mental Hygiene. Integration of Heelihem 27 is marked other then "natureli, or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examinar must be notified at once.		1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cen	netery, cremato	ory or other	ົ ^{place)} ↓ Jເ		15,			
===	nit. P artme ortan injur		21. Signature of Functor Service Licens		1 200			ddress of Facility	2008	В	west	che	ster, PA
B	permi Depa Impo any Ir		1 Steel			And	drew	G. Geé					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	the death,	Do not enter th	he mode of	Main St dying, such as car	diac or i	Elkto respiratory ar	on, MD	-2	1 9 2 1 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	io causo on oach iii	As	what	Time	~				ŀ	Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	ence of)	,0,,00						
	Examiner		Sequentially list conditions,	0									
PCT	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se	a sonseque	nec off:							
	ficate be executed physician and is the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as	a conseque	ince of):						-	
8760.	be exiclan	aE											
687	ficate be physicle is the bur	edical		3									
PC/ Box	death certif e ettending id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							23d. Da	ate of deli	very
$>$ $\overline{}$	death	by Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			topic pregn ther (s <i>pecif</i>)				Mo	onth	Day Year
- O.9	at the de by the tached	hys	9 Unknown	9□ Unknown							1		
	The law requires thet the death certificate has been signed by the ettending age 2 should be detached for use a	by	Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the unde	rlying cause	e given in Part I.					the cause of death?
N_{ℓ}	v requir been si should	ted							- //	101	′es 2□No	3 □ Pr	obably 4 ⊠Unknown
ec -	e taw has b	Completed							_	24a. Was autop	SV	prior to d	topsy findings available completion of cause of
	: The	Co										death?	2□ No
Z Z	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		,		Other		Check only o			
Arthul sion of VII	Phys rathis	5	1 ☐ Yes 2 ☐ No	1 ☐ Inpatie		R/Outpatient 28b. Time of	3□ DOA				dence 6 Oth		oify)
- 6	ding Ith. Th. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	20	d. Describe i	iow injury occur	100	
Arthul mac Division of Vital Records.	Attending Physician: r death. ector: After this certification, the funeral director.	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At hom	ne, farm, street,			28			ber or Ru	ıral Route Number,
وَ	s efte	Certification;	4 Homicide	building, et	c. (Specify)					City or Tov	vn, State)		
	To the Hospital or Attending Physician: The lawithin 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	cal	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my know	ledge, death oc	curred at the	ne time, date and p	lace, an	nd due to the	cause(s) and m	anner as	stated.
	To the H within 24 To the Fi complete	Aedical	one)	and manner sta	ated.	and or invest			OCCUIT 0C				
	To To	Σ	29b. Signature and title of certifier	MA			29c. Li	cense number	Chr	4-	29d. Date signe	ed (Monti	n, Day, Year)
			1 4 9	11.12.				1446	W 5	10	July	14	1 2000
	ELLIA		30. Name and address of person who con ALFIE MINGO M.	ompleted cause of d	S / /	23a) (Type, Prin	Ave	HAUre	10	GDA	0 M	1. 2	1078
(5-+ VA Sta	te	31. Date filed (Month, Day, Year)	32. Revistr	ar's Signatu	NION /	100	UITIVIE	45	UKA(- 1016	1.0	1010
	Registr		JUL 1 5	2008	Cock !	D. 40	and I	•					

Registrar

State

WEINER, MD GUN BESTEGAK ROOD #300, Annagulis, MD

Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the

1000

NRS State Registrar 29b. Signature and title of certifier

Gamar W

31. Date filed (Month, Day, Year)

JUL 0 7 2008

Zaman M.D 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904 Seton Drive Suite 203

29c. License number

D0023371

29d. Date signed (Month, Day, Year)

2002

		For State Registrar		-		and / Dep <i>Ce</i>		t of ⊢	lealth a		1ental Hy			8 2421
Physici	an	1. Decedent's Name (First, Mic Matilda Mc									2. Date of Dea	ath Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institut	sley ion, give		ber)		4b. City, 1	Town, or	Location o	of Death		4c. C	County of De	
LAGITAT	CI.	Manor Care He	_				1		Spri			Мо	ntgom	ery
Funeral Director		5. Social Security Number 571–30–0955	6. Se			yrs. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 12/20/	th y, Year) 1919	9. B	irthplace (State or Foreigr Country) SC
land ow		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c.	City, Town or Le	ocation							10d. Inside City Limits
Mary ia-fsh	ctor	MD Princ	e Ge	orge's	H	yattsvi]	.1e							XXYes 2 ☐ No
ith the	Dire	10e. Street and Number					10f. Zip					10g. Citiz	en of What C	Country?
s 23a	eral	2400 Queens C	hape			-110		782	ii- O-i	-:-0 /0-	:6->6		USA	day to day
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exactivation use to confined at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ☒ Widowed 4 □ Divorc		12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	₽ K] No	n U.S. 13.	was Decedi If Yes, speci 1 ☐ Yes 2			gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		Black, Wh	nerican Indian, ite, etc. lack
21215-0036 d within 72 hours aft gliene. er than "natural", or it is Modical Exc.	mpleted	15. Deced (Specify only high Elementary/Secondary (0-12	nest grad	ication le completed) College (1-4	4or 5+)	(Give	dent's Usua kind of work DO NOT us	k done c e retirea	during mosi ()	t of work	ing		d of Busines	s/Industry
Hygier the		12 17. Father's Name (First, Middle	a Lact)			Silk	Fini	sner		r'a Name	(First, Middle,	Priv		
Maryland d 2 should be file th and Mental Hy traumatic event	To Be	Lucius Young							Ange	elin	e Nicho	lson		
Mal d2sh tth and t7 is n		19a. Informant's Name/Relatio					-				al Route Numbe			, Zip Code) MD 20740
re, s 1 an f Heal tem 2		William Simpki 20a. Method of Disposition	ns/r	repriew	20	b. Place of Disponentery, cre					Date Out			or Town, State
Pages eent or nt: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	ı 3∭I (Specify	Removal from St	aue i	cemetery, cre Millers				7/15	/2008	Aike	en, SC	
Baltimore, permit. Pages 1 ar Department of Hee Important: If Item any Injury or othe		21. Signature of Funeral Service			/	2	2. Name and	d Addres	ss of Facilit	у Ма:	rshall's W Wash	s Fur	neral	Home 20011
Physician /Medical		23a. P de Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or comp st only o	ne cause on ea	ch line.	dio-2					or respiratory a	rrest,		Approximate Interval Between Onset and Death
ate be executed the burial-transit and the bu	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	$\left\{ \right.$	b. Due to to	erac a conn	sequence of):	opar	17	9					
or Attending Physician: The law requires that the death certificate be executed after death. Careful after death certificate be executed for death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		23c. If yes, outco 1 ☐ Live bii 4 ☐ Pregna 9 ☐ Unknoo	rth 2□F ant at time	etal death 3	□ Ectopic pr □ Other (spe		y			2:	3d. Date of o	lelivery Day Year
quires that quires that an signed b	è	Part II. Other significant condi	tions co	ntributing to dea	ith but not	resulting in the u	nderlying ca	use give	en in Part I.		23e. Did to			to the cause of death? Probably 4 Unknown
The law requires the law been signed as the law been signed page 2 should be on the law to be controlled.	Completed	CVA		de In	CAT.	sa_					24a. Was autop perfo 1 □ Yes		prior to death	autopsy findings available o completion of cause of ? es 2 \(\square\) No
Or VICAL F Physician: The rthis certificate I ral director, page	Be	25. Was case referred to medic examiner?	⊢	Hospital:				Othe		of Deat	n (Check only o	ne)		
This Pry 2	<u>۽</u>	1 Yes 2 16		1 ☐ In		2 ER/Outpatie		A	4 UNU		me 5 Residence R			pecify)
l or Attending Ph after death. Director: After th d in by the funeral	Certification:	1 Dentatural 5 Pend 2 Accident inves 3 Suicide 6 Coul	tigation	(Month	, Day, Yea	r) Injury It home, farm, st	М		(?¯` Yes 2 □ I	No		Street and		Rural Route Number,
Hospital 14 hours (17 hours) 15 Funeral (18 filled)	Medical Cer	29a. Certifier (Check only one) Certify 2 Medic	ring Phy al Exam	sician: To the b	est of my	knowledge, dea	th occurred anvestigation,	at the tir in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the	cause(s)	and manner place, and d	as stated. ue to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certif	ier 2	hull	/	M.L	29c.	_	e number	36			signed (Mo	nth, Day, Year)
		30. Name and address of person	n who co	ompleted caus	eath (Item 23a) (Type,	Print) Sh	R	yet,	SEG	on St	DI	Kaj	Les HP 200
Sta Registra	_	31. Date filed (Month, Day, Yea		1 69	gistrar's Si	gnature A	arti							

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3.47AM Veryle Mumma July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–13–1954 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days **X**XM 2□ F 164-46-6617 53 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director PA Franklin Hamilton Township 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2792 Edenville Road 17202 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired)
Pipe Cutter traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 In and Mental Hygiene. 7 Is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) Pipe Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beulah Mellott Veryle L. Mumma_Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tina Mumma Important: If Item 27 any Injury or other tr (wife) 2792 Edenville Road, Chambersburg, PA. 17202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawns Memorial Gar. 7-25-08 Chambersburg, PA. 4 ☐ Donation 5 ☐ Other (Specify) M01414 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. L. Davis Funeral Home reffer 12525 Bradbury Ave., Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Negative **Physician** Rod disease or condition resulting in death) day /Medical Due to (or as a conse up nce of): Examiner Compartment Syntone Section titally life to cultione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed Host Disease Versus 1ears burial-trar and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending | for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 Tho certificate 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7466 2008 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Baltimore, eann Silhan 22 South Greene Street 32. Registrar's Signature 31. Date filed (Month, Day, Yea JUL 2 8 State Registrar

Show In

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 21, 2008 9:30 July NILLES PHILIP JOHN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 □ F 1941 Maryland 66 217-38-6156 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylano nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evanimer must be invitined at 1 ☐ Yes 2 No Bel Air Directo Harford MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 United States 621 Lee Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify ≥ White 3 Widowed 4 Divorced 1963 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Seechuk Mary John Nilles Dorothy Philip ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and l 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Fallston, MD. 21047 3023 Bellechasse Rd. Jeff Nilles (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Carroll Cremation 7/23/2008 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sergice Ligensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Gladden Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final osteomelitis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Sacral Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 54 attending physician and Due to (or as a consequence of): Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death buy not resulting in the underlying cause given in Part I. ģ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No this certificate 1 🗆 Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

law requires that the death certificate be executed Records, Vital ot lospital or Attending P I hours after death. uneral Director: After t Division Hospitai within 24 hours a completely

Maryland 21215-0036

Baltimore,

68760,

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State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mesa

Apunva

31. Date filed (Month, Day, Year)

_	Type of the Diagram and Diagra
	State of Maryland / Department of Health and Mental Hygiene
	On wife and of Double

		For State RegistrarAMEND	#20h anan				epartment o Certificate d			ental Hyg	ene g. No. 2 (008	24219	
		Decedent's Name (Fig. 1)	irst, Middle, Las	rη, /-25-(, Mrd , O	<u> </u>				Date of Death Month		Year	3. Time of Death	
Physicia /Medic		I	Rose Owa	ambo						July 6,	2008		5:03 PM	
Examin	er	4a. Facility Name (If not			,		4b. City, Tow					y of Death	27	
Funeral	-	Shady Grov 5. Social Security Numb			pital Age (In yrs. I	last birtho	lay) If Under 1 Ye		der 24 Hrs.	8. Date of Birth		tgome 9. Birthp	place (State or Foreign	
Director		214-73-60	79	□M 2 X F	2	4 Yrs	Months Da	ays Hou	ırs Min.	Oct. 1,	1983	Ken		
w w		Usual Residence of Dec	cedent b. County		10c. City	v. Town o	r Location					1	0d. Inside City Limits	
Maryia f sho	tor			. 1617			hersburg						1⊠Yes 2 No	
r 28a	Director	MD 10e. Street and Number	Montgome r	EL Y		Gart	10f. Zip Cod	de		10	og. Citizen of	What Cour	ntry?	
th with	al	105 Kestr	el Ct.					0879				enya		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will be required at once.	by Funeral	11. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4 ☐		12. Was Deceder Armed Forces 1 Tyes 25 If Yes, Give Year or Dates	s? ₹ No	S.	13. Was Decedent If Yes, specify (ecify Yes or No- Rican, etc.)	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: African			
ithin 72 hor ne. nan "natura Nedical I	Completed	15. (Specify of Elementary/Secondar	Decedent's Ed only highest grad ry (0-12)	de completed) College (1-4o	r 5+)	(6	ecedent's Usual Od Give kind of work do fe. DO NOT use re	one during i etired)		ng	16b. Kind of		dustry	
iled w Hygier ther th		17. Father's Name (Firs	et Middle Last)	5		Adm	issions			(First, Middle, N		llege		
d be f ental I ked of	To Be	Leonard O							Mary A			,		
shoul and M s mari	۴	19a. Informant's Name		ype. Print)		19b. N	lailing Address (St				City or Tow	n, State, Zij	o Code)	
and 2 ealth a n 27 is		Leonard O	wambo	-father		105	Kestre1	Ct.	Gaithe		_			
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permit. Depart Import any inj		21. Signature of Funera	ne)	1 Keg	mil		7400 Geo	rgia	Ave.,	N.W. Wa	shingt		ce, Inc. .C. 20012	
Physician /Medical		23a. Part 1. 7 for the d shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)		a. Advanc	ed Ai	ds		dying, suc	h es cardiac d	or respiratory arm	est,		Approximate Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 ☑No 9 □ Unknown	nths?	23c. If yes, outcor 1 Live birth 4 Pregnan 9 Unknown	n 2∐ Feta t <i>a</i> ttime ofd	d death	3 ☐ Ectopic preg 5 ☐ Other (special					Date of delivery	very Day Year	
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siclan certif rector	Be	25. Was case referred examiner? 1 ☐ Yes 2 🛣 No	to medical	Hospital:		I FR/O: t-	-tit 0 0 00	Othori		h (Check only or		Othor (Cross		
ending Phy eath. or: After this he funeral d	Certification: To	27. Manner of Death 1 Natural 2 Accident	☐ Pending investigation	28a. Date of I (Month,		28b. Tin Inju	atient 3 DOA ne of 28c. M	Injury at Work? 1 Yes		me 5 Resid	ow injury occ	urred		
vital or Att urs after d ral Direct		4 Homicide	determined	building,	etc. (Specii	fy)	n, street, factory, of			City or Tow	n, State)		ral Route Number,	
the Host hin 24 ho the Fune npletely fi	Medical	(Check only 2	Medical Exan	ysician: To the be niner: On the basis and manner	s of examina	owledge, o ation and/	death occurred at to	the time, da my opinion	, death occur	red at the time, o	cause(s) and late and place 29d. Date sig	e, and due	to the cause(s)	
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7	_	38 Name and address				,		1850	Shahru	at Davar	- <i>J</i> -		- 0	
Sta Registr		9901 Medic 31. Date filed (Month, I		32 Regi	strar's Signa	ature	le, MD 20	J03U 1	onanty	at Daval	<u> </u>			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2250 6 OB 26 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner edical Center 100mico If Under 1 Year Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** De aware 1**⊠** M 2□ F Months Days 221-80-6830 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a lifetial Examiner must be notified at 1 Yes 2 No Funeral Director minaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9803 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame) Be pe 1 ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Styeet and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 I Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. ö 4 □ Donation 5 ☑ Other (Specify)

21. Signature of An ray Service Lineare 07-03 remutory 22. Name and Address of Facility 1980 runeral 11m 23a. Part 1. Er of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Quse (Final disease or condition resulting in death) **Physician** hrs Multiple Trauma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death detached 1 □ Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 2 No 3 Probably 4 Unknown 1 🗌 Yes been s Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 🗆 No 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 2 Accident 6/26/08 2145 1 ☐ Yes 2 No ATV Accident after death Director: by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide off road 6/0 Systex Cty Rd To the Hospital within 24 hours 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 175049 30. Name and address of ompleted cause of death (Item 23a) (Type, Print) St myde 100 E Carroll

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

1 6 2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Month July **Physician** 20 11:30 AMM Silas Carroll Phillips, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 811 Shawnee Drive Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Year) 1 ₩ 2 □ F Months Days Hours Sept. 6, 1930 Virginia 212-24-5523 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "te Medical Examinar must be natified at Maryland Frederick Frederick 1 MYes 2 No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 811 Shawnee Drive 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 tgYes 2 ≥ No If ₹es, Give 1949-1953 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. Ith and Mental Hygiene. '7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 11 Car Shop Foreman/Maintenance Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll Dwayne Phillips Lorretto E. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Mrs. Blanche J. Phillips, wife 811 Shawnee Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens July 28, 2008 Frederick, MD 22. Name and Address of Facility
Keeney and Basford PA Funeral Home 21. Signature of Euneral Service Licensee Kin E 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** de disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-transi and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 24 hours after death. Pruneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

29b. Signature and title of certific

Medical

31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

skander

and manner stated



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

July 21, 2008

Frederick, MD 2170

To the within 2

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1543 P^{M} 2008 8 July John Penn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery <u>Rockville</u> 9. Birthplace (State or Foreign Country)
NC If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/1/1921 5. Social Security Number 7. Age (In yrs, last birthday If Under 1 Year **Funeral** Hours Days 1 🛣 M 2 🗆 F 87 Director 241-40-7760 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Modical Examinational Econollical at ones. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director VA Fairfax Fairfax Station 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22039 7109 Sylvan Glenn Lane USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th <u>Maintenance Worker</u> Gallaudet University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Dolan Penn Alma Hill ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 200111 504 Oneida Place, NW Alma Shearard/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/14/2008 Alexandria, VA Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 20011 4217 9th STreet, NW Washington, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Dementia <u>hours</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy 2 🗆 No 1 ☐Yes 2 ☑ No 1 ☐Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1₺ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 ីX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific July 9, 2008 D0064413 1mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juanita L. Smith, MD 9901 Medical Center Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 14 2008

Sh. B.

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 July 12 4:50 A M Ian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hogpital 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1□M 2□ F Director Trinidad 118-46-0495 65 Jul.9, 1943 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 28a-f show 10c. City. Town or Location event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1720 Luzerne Avenue 20910 HSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 0. Maryland 21215-0036 1 ☐ Yes 2√2 No Specify ð 3 Widowed 4 Divorced 'natural", Indian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Television Department of Health and Mental Hygie important: If Item 27 Is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Narsaloo Ramaya 9 Baby Rookmin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Luzerne Avenue, Silver Spring, MD 20910 Baltimore, Gemma Ramaya/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 ment of F 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory July 13 Alexandria, VA 4 Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Collinst 300 UNIVERSITY Bluckers DISTONU tome 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -ardiofulmong disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Lateral Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner law requires that the death certificate be executed RVRYR Theumatoid burial-tran and resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, physician the use as attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Por in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy Hospital or Attending Physician; The performe 2 No 2 🗆 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of After t 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the ٩

State

Registrar

31. Date filed (Month, Day, Year) 14 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D00661

29d. Date signed (Month, Day, Year)

			State of I 1 - State AMEND#7, perFH, 7/17/08, DES	Maryland / Depa S , McCo <i>Cel</i>	artment of F rtificate of			giene neg. No 2008	24225
	Physici		1. Decedent's Name (First, Middle, Last) Carlos Alfonso Delga	do Rodriguez			2. Date of Dea Month July 9	th	3. Time of Death 5:03 P M
4	/Medic Examin		4a. Facility Name (If not institution, give street and numb Shady Grove Adventist Hos	er)	4b. City, Town, o			4c. County of Deal	n ry
	Funeral Director		5. Social Security Number None Sex 1	Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 1	4-18-58 9. Birt 7. Year) 9. Birt Co 5, 1958 Co 1	thplace (State or Foreign ountry) ombia
	Maryland	ctor	10a. State 10b. County Colombia Modelia Real	10c. City, Town or Lo	ogota				10d. Inside City Limits 1 □Yes 2√2 No
	3a or 28	al Director	10e. Street and Number Trav 88B #23D81 Int. 1 A	pt. 501	10f. Zip Code	one		Og. Citizen of What Co	untry?
036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ledical Evanting mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give	ent Ever in U.S. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13		dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify His]	e, etc.
9500-61213	2 6 3	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-44)	or 5+) (Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	ing	16b. Kind of Business/	
andz	be filed Ital Hyg d other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)	<u> </u>
II YIB	should Ind Men marke marke	ပ	Alfonso Delgado 19a. Informant's Name/Relationship (Type. Print)	19b. Mailiu	ng Address (Street		ia Rodri	guez r, City or Town, State, 2	Zin Code)
, K	and 2 salth and 2 salth and 27 la		Carmen Alicia Quijaro Reslen/W		-			elia Real-Bog	•
ore	ages 1 nt of Hi : If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Disponsion Cementer, crementer 1 De Chapin	sition (Name of natory or other plac O	ce)		20c. Location - City or	
Банито	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 Ia marked other than "any Injury or other traumantic event, I'm. New Once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility ROD	ert A. P	Bogota, Col Pumphrey Fu Iontgomery	neral Home/
	Physician		23a. Part1. Error the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	sed the death. Do not ent h line.	er the mode of dyir				Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>	resulting in death) Due to (or	as a consequence of): RATORY F	AILURE				
'n	executed an and ial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	NEGATIVE as a consequence of):	E SEPSI	\$			
00/00	ificate be g physicia s the bu		d. META	STATIC TES	STICULA	R CANC	ER	51 Ko	
O. DOX	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Inhance Abous after death. The Inhance Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M		h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
cords, r	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death	h but not resulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to es 2 ☐ No 3 ☐ P	o the cause of death?
מו שבני	ding Physician: The law ra n. After this certificate has be funeral director, page 2 sh	Completed	ACUTE RENAL FAILUR	.€			24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
5	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 No Inc.	atient 2 ☐ ER/Outpatier	ot 3 🗆 DOA Oth	er: 4 \(\sum \) Nursing Ho		ne) ence 6 ☐Other (Spe	oity)
5	nding Physician: The lath. r: After this certificate hate funeral director, page	ation: T	27. Manner of Death 28a. Date of I		28c. Injur Worl			ow injury occurred	City)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, streetc. (Specify)	eet, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	e Hosp 24 hou e Fune letely fil	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or in	h occurred at the til vestigation, in my o	me, date and place, ppinion, death occur	and due to the or red at the time, o	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	To th comp	Me	29b. Signature and title of certifier	N 1	29c. Licens		_	29d. Date signed (Mont	
	10		30. Name and address of person who completed cause of		Print)	6447		July 10, 2	
	Sta	te.	Fisenhatsion Mehari, 9901 31. Date filed (Month, Day, Year) 32.	Medical Cerstrar's Signature	nter Driv	e, Rockv	ille, Ma	ryland 208	50
	Registra		.1111 1 4 2008	M. K. Bo	ast 1				

DHMH 17 Rev 1/2001

08-05260 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James M Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle i ast) Month Day July 8, 2008 Medical Examiner <u>James M. Smith Jr.</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours Director 215-86-9043 1 X M 2 47 2/21/1961 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County or 28a-f show I other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Maryland Prince George's Colmar Manor with the Maryland Director 10e. Street and Number 10f. Zip Code 3817 Newark Road 20722 ē 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: Divorced Yes, Give Yes Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ , MD 21215-0036 and 2 should be filed within 72 salth and Mental Hygiene. item 27 is marked other than traumatic event, the Medical Roofer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James M. Smith Sr. Be Margaret M. Tate it. Pages 1 and 2 should be ritment of Health and Menta retant: If item 27 is marked y or other traumatic eventy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ James M. Smith Sr./Father 3817 Newark Road, Colmar Manor, MD 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition Date Baltimore, crematory or other place Burial 2 X Cremation 3 Removal from State Important: I Fort Lincoln Crematory 7/17/2008 Brentwood, MD Donation 5 Other Specify 22. Name and Address of Facility Fort Lincoln Funeral Home 21 Signature of Funeral Service License 3401 Bladensburg Rd., Brentwood, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical Hypertertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit of Vital Records, P.O. Box 68760, P.P. Box 68760, Physician: The law requires that the death certificate be executed Physician/Medical \mathbf{x} AMENDED #1 as noted, 23a,27,per MEG882 8/14/08 TT attending physician a X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Pregnant at time of Other (Specify) 5 signed by the atto 1 Yes 2 No 9 Unknown a Unknow by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š Completed has been si 2 should b 24a. Was an autopsy performed: certificate funeral director, page ✔ Yes 2 No Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other4 Hospital: DOA Nursing Home 5 Residence 6 this Inpatient 2 FR/Outpatient 3 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work Certification: 1 X Natural Division Yes 2 No Pending Funeral Director: etely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the I within 2 To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

2008 24226 1949 hrs 4c. County of Death Prince George's Foreign Country)W.V. 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify White 16b. Kind of Business/Industry Function Enterprises 20c. Location - City or Town, State Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

Other

July 9, 2008

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State

Registrar

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Laron Locke MD

2008

I. Date fil filed (Mer

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 08, 2008 17:45 Nancy Stakem /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 404 Park Street Allegany Frostburg Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 □ M 2 X F 52 Maryland 215-68-7102 Director September 03, 1955 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura!" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No Director Frostburg Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 404 Park Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) case worker social services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Richard C. Stakem Katherine Davis ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Stakem 21539-Maryland Rister 16307 Gold Run Road Lonaconing 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State July 10, 2008 Cumberland Maryland **Cumberland Crematory** 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** S CVDA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day for in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4□Pregnant at time of death ed by the a detached f 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has by page 2 s autopsy performe 1 Yes 2 No certificate or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the .
within 24 hours a.v.
To the Funeral Direct 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) AUI SLEXU W. CumberLAND, MD nas

Registrar DHMH 17 Rev 1/2001

State

MO

JUL 1 0 2008

31. Date filed (Month, Day, Year)

Box 68760.

P.O.

Division or Vital Records,

Physician
/Medical
Examiner

Funeral

Director

death with the Maryland 28a-f show other traumatic event, the Medical Examiner must be notified at 6 items 23a Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or iter Department of H Important: If ite any injury or oth

3altimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transi and P.O. Box 68760. attending physician for use as the buria signed by t Records, Division or Vital funerai After

or Attending Physician: death. within 24 hours after death To the Funeral Director: To the Hospital 2 nes

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Voor MARIE GLADYS STANTON 06 25 2008 1620 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 82 216-22-5818 01/14/1926 West Virginia Usual Residence of Decedent 10a State 10c. City. Town or Location 10d Inside City Limits 10h Counts Allegany 1 Yes 2 No Director Frostburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 153 W. Main Street 21532 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. ρ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Griffiths Eva Pearl Crowe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi M. Galliher / Daughter 162 W. Mechanic Street, Frostburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 106/28/2008 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Li 404 Decatur Street, Cumberland, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. P. H. L. Leter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) □Yes 2□No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CumberLand MD 21502 QAMAR ZAMAN RIVE Seton 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 7 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1, 2008 1833 Herbert July Charles Stotler, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25702 Piclic Road, NE Flintstone Allegany 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 □ F 76 236-44-4826 02/03/1932 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c, City, Town or Location 10b. County 1 Yes 2 No Director MD Allegany Flintstone 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25702 Piclic Road, NE 21530 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Service Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stotler Emmett Marv Magdeline Shepherd 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25702 Piclic Road, NE., Flintstone, MD Helen L. Stotler / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Sunset Memorial Park 07/05/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sona ure) f Funeral Scrude Lice 22. Name and Address of Facility Adams Family Funeral Rome, F.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed page 2 2 💢 No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Innatient funeral 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and e of certifie D16041 July 2, 2008 à 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry E. Williams, M.D., 500 Memorial Avenue, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Reastrar's Signature State JUL 0 3 2008 Eleva Registrar

DHMH 17 Rev 1/2001

Certificate of Death

3. Time of Death

9:00 A

10d. Inside City Limits 1 No Yes 2 No

 Birthplace (State or Foreign Country) Maryland

			1. Decedent's Nam	e (First, Middl	e, Last)									2. Date of D				3. Time of De
	Physic		Rut	h I	Maxin	ne.	Sinn	ott						July	20	ay	2008	9:00 A
	/Medi Exami		4a. Facility Name (1011	4b	. City. T	own. or	r Location	of Death	July			of Death	9.00 A
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	Funeral	_	5. Social Security N		6. Sex	sirter	7. Age (In	yrs. last birt	hdav) If	Under 1		ninst If Under		8. Date of B	irth		arrol 9. Birtho	place (State or Fo
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	if o	금	10e. Street and Nu	mber					11	Of. Zip C	Code				10g. C	itizen of	What Cour	ntry?
	after deeth w or Items 23e	E	1234 W	Vashing	ton l	Rd.						2115	57				U.S.	Α
	e m	Funeral	11. Marital Status		12	. Was Dec	edent Ever	in U.S.	13. Was	Decede	ent of H	ispanic Or an. Mexica	igin? (Sp	ecify Yes or N Rican, etc.)	lo-		ce - Americ	
21215-0036		by	1 X Never Marr 3 ☐ Widowed			1 ☐ Yes If Yes, Gi Year or D	2 X No ve			Yes 2		Specify		, 1102.1, 010.1,		Specif	fv	ite
9	72 hours natural,	Completed	(600)	15. Deceden	t's Educa	tion		16a.	Decedent's	s Usual	Occup	ation			16b.	Kind of B	lusiness/In	dustry
21	hin 7	D E	Elementary/Seco	cify only highe. andary (0-12)	st grade d	College (\rightarrow	(Give kind life. DO N	or work VOT use	retired	during mos d)	st of work	ing				
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D	other tile	Bec	17. Father's Name	(First, Middle,	Last)								er's Nam	e (First, Midd				
a	d be ental	To B	Lamos	Leon S	Sinno	.++ 0.							جا يد	D1:				
2	2 should be filed within and Mental Hygiene. Is marked other then aumatic avent, ILE M.	=	19a. Informant's N				•	19h	Mailing Ac	deace ((Stroot :			Paulin al Route Num	The same of		to primary many	Codel
Maryland	d 2 s th ar T is		Jennifer			. ,												
	ss 1 and 2 of Health item 27 i		20a. Method of Dis		L/ II	rece	20	Ob. Place of				ute		Date	,			OH 45331
ō	8°= 5		1XXX Burial 2	•	3 □Ren	noval from	- 1	cemeter	y, cremator	ry or oth	her plac	(e)		Date	20c. i	Location	- City or To	own, State
븚			4 Donation	5 Other (S	pecify)		M	lounta			-	1.0		2008	Un	ion	Bridg	e, MD
Baltimore,	permit. Peg Department Important: I any Injury o		21. Signature of Fu	Beral Service	License	V/	10	?	22. Na	me and	Addres	ss of Facili	y Ha	rtzler	Fun	eral	Home	
ш	40 E = 0		· Carr	prine	0-	XVIA	rise		6 E	. Bi	road	dway	Un	ion Br	i dge	, MD	2179)1
			23a. Part1. Enter t	he disease, or art failure. List	complica	tions that	caused the	death. Do n	ot enter the	e mode	of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Betwee
	Physician		Immediate Cause	(Final	only one		Sacri III Io.	1	1.		x-	T	1	2			,	Onset and Dea
	/Medical		disease or condition resulting in death)	on	a	Dualo	(or as a cor	e a cuardo a	JA	ac	, ,	/n-	fu	con			-	(W
	Examiner				•		0 4 4	ISACIANCA	<i>n</i>).			l	/					2. 1
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	nsit	Examiner	cause. Enter Unde Cause (Diseese or	erlying injury	<	0,	2.02	7 4 4 4		1	0		1.	1				2
	e be executed rsicien and e burial-transit	хаг	that initiated events resulting in death) I	3	c	Due to	(or as a con	Seguence	sew	m	N	ec	· pr	w-				nn
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87	difficate ng physi as the l	dica			d											-		
Box 68760,	ing p	Physician/Medical	IF FEMALE:		T								-					
9	eeth cert ettendin for use	an/	23b. Was deceden		23c	. If yes, ou 1□Live t	tcome of propirth 2 1	egnancy Fetal death	3 □Ecto	pic pred	anancv						ate of delive	
_	he a	sic	1 ☐ Yes 2 [No			nant at time		5 🗌 Oth							MI	onth	Day Yea
P.0.	that the de ned by the e detached i	² hy	9 ☐ Unknown												1			
	The law requires that the deeth certificate be executed to be been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by	Part II. Other signif	ficant condition	ns contri	buting to d	eath but not	t resulting in	the under	ying cau	use give	en in Part I		23e. Did	tobacco	use con	tribute to t	he cause of deat
P	w require been si should I													10	Yes :	2 1 No	3 Prot	ably 4 Unki
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Be	he la e he:	Ĕ												aut	opsy formed?		prior to co death?	psy findings avai mpletion of caus
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₹	ysician: The is certificate he director, page	Be	25. Was case reference examiner?		Hos	pital:	_			_	7 04-		of Death	h Check only	one)			
o to	Phys this al dii	٤	1 Yes 2			יוי		2 ER/Out		□ DOA		4 NI		me 5 Re				y)
Division of Vital Records,	iding Physician: th. ; After this certifice funeral director, p	Certification:	27. Manner of Death	5 Pendin		ZBa. Date (Mon	of Injury th, Day Yea	28b. T	ijury		c. Injury Work		1	28d. Describe	how inj	игу осси	rred	
Sio	eath for; /	cat	2 Accident	investig	ation -					4		Yes 2 🗆						
Ξ̈́	r Att	1	3 ☐ Suicide 4 ☐ Homicide	6 Could r determ	ined	28e. Place buildi	of Injury - ing, etc. (Sp	At home, far	m, street, f	actory,	office			28f. Location City or T	(Street a	and Numi	ber or Rura	al Route Number,
	Ital or rs atte at Dir led in	Ce																
	To the Hospital or Attent within 24 hours atter deatl To the Funerat Director; completely tilled in by the		29a. Certifier (Check only	1 Certifyin	g Physic	ian: To the	best of my	knowledge	death occ	urred at	t the tim	e, date ar	nd place,	and due to th	e cause(s) and m	anner as s	tated.
	n 24 ha Fi	Medical	one)	∠ _ medical	examinei	r: On the b	asis of exam ner stated.	nination and	Vor investig	gation, ir	n my op	pinion, dea	ith occurr	red at the time	, date ar	nd place,	and due to	the cause(s)
	To the Within To the	Σ	29b. Signature and	title of certifier	7	-	111			29c.	License	e number			29d. D	ate signe	ed (Month,	Day, Year)

al Home MD 21791 Approximate Interval Between Onset and Death d. Date of delivery Month Day Year contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other (Specify) ccurred Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:28 PM Shects Dean arry 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BÁLTMOVE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore A N medical Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) 1□M 2□F **Funeral** Director 219 56 2826 12/29/1950 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be maritimed as 10d. inside City Limits 10c. City, Town or Location 10b. County 1**X**Yes 2 ☐ No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1736 Dearwood Court U.S.A. 21040 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Maritai Status Black, White, etc. 1 XYes 2 No if Yes, Give Year or Dates: 1970 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Reed Sheets Julia Ruth Osborne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 Dearwood Court, Edgewood, Maryland 21040 Brenda Sheets 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 7/24/2008 Aberdeen, Maryland Gardens 21. Signature of Funeral Servige Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St. Aberdeen, Maryland 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or completions that cluyed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 212 No ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Naturai 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July NPT: 1497914535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene St Baltimore MD 21201 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 8 2008 Registrar

2/1

ORIGINAL

Registrar

			_ For	State of Maryland	d / Dep	artment of H	lealth and M	ental Hy	giene	2008	21	.231
			1 - State Registrar		Ce	ertificate of	Death		Reg. No		<u> </u>	7200
100			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Da	av Year	3. Time	of Death
	Physici: /Medic		Doris Jane Sch	ulten				July 1			12	2:14 a
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		40	c. County of Death		
*			15401 Bassett L	ane, Apt. 2D		Silver	Spring			Montgome	ry	
	Funeral		,	Sex 7. Age (In yrs. la 1 ☐ M 2x☐ F) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year	9. Birth		te or Foreign
	Director		210-16-3367	86	Yrs.			Oct. 1	17,	1921 Pen	nsylv	ania
	w		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or L	ocation					10d. Inside	City Limits
į	sho sho	ō										es 21 No
	the A	Director	Maryland Mon 10e. Street and Number	tgomery	Silv	er Spring			10a C	itizen of What Cou	ntry?	
3	a or	ä				· ·			109. 0			
	eath is 23 must	Funeral	15401 Bassett L	12. Was Decedent Ever in U.S	13	20906	dispanic Origin? (Spe	cify Yes or No	- T	USA 14. Race - Ameri	can Indian	
	iter d	ä	1 ☐ Never Married 2 ☐ Married	Armed Forces?	,. ,0	If Yes, specity Cub	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		Black, White		
5	irs af Il", or xam	by I	3 → Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify: Wh	ite	
5	2 hou atura cal E	pe	15. Decedent's E	ducation		edent's Usual Occup			16b. l	Kind of Business/Ir	dustry	
2 1	Media 1	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Giv life.	e kind of work done DO NOT use retire	during most of worki d)	ng				
7	giene sr tha	ĕ		4	Regi	stered Nu	ırse			Health	Care	
2	othe othe vent,	Be	17. Father's Name (First, Middle, Las)			18. Mother's Name	(First, Middle,	Maide	n Surname)		
5	uld b Ment; rked tic e	ToE	Henry Yocum			ľ	larguerite	Elizak	oeth	Johnson		
Ē ;	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	and Number or Rura	al Route Numb	er, City	or Town, State, Zi	p Code)	
Ž :	and 2 salth 27 I er tra		Carl Schulten/S	on	852	21 Paddock	view Driv	e, Lay	cons	sville, M	D 208	382
ט ז	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Becaute of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ➡ Cremation 3 [20b. Pla	ace of Disp emetery, cr	position (Name of ematory or other place	ce)	ate	20c. L	_ocation - City or T	own, State	1
	Pag ment ant: I		4 Donation 5 Other (Special		ropol	itan Crem		ly 11,	P	Alexandri	a, Vi	rginia
	permit. Departi Importa any Inj		21. Signature of Funeral Service Lice	nsee	F	22. Name and Addre	ess of Facility. Collins	Funeral	L Hc	me Inc.		
0	8. 5 E F 9		Allon M	Jenye			sity Blvd				g, MI	2090
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	. Do not e	nter the mode of dyin	ng, such as cardiac o	or respiratory a	rrest,		Approxi	Between
F	Physician		Immediate Cause (Final disease or condition	_a Sepsis							Onset a	nd Death
•	/Medical		resulting in death)	a. <u>Sepsis</u> Due to (or as a consequ	ence of):						ı we	er
E	Examiner		Convention, list conditions	, Gangrene of	Lower	Extremit	cies				2 we	eeks
	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):							
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	C. Vascular Occ		on					2 we	eks
5	e exe an al urial-t	Ä	resulting in death) Last	Due to (or as a consequ	•							
00.0	ficate be executed physician and sthe burial-transit	dical		Peripheral V	[ascu]	lar Diseas	se				unkr	iown
5	ntiffica ng ph as tl	Ned	IF FEMALE:						1			
5	th ce tendi r use	an/	23b. Was decedent pregnant	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal		□Ectopic pregnanc	:v			23d. Date of deli	-	
	dea deat ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		☐ Other (specify) _				Month	Day	Year
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ń	es th igned be de	by	Part II. Other significant conditions		_					use contribute to		
ָהָבְּיה, היים	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ted	<u>Diabetes Mellitu</u>	s, Severe Alzhe	imer	's Disease	9	10	Yes	2 √√N 0 3 □ Pro	bably 4	Unknown
נו	faw l as be 2 sh	ple						24a. Was		24b. Were au	topsy findit	ngs available
	The ate h page	Completed						perfe 1 Yes	ormed?	death?	2 □ No	
12	ysician: The faw is certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Deat	n (Check only	one)			
-	ysk is ce dire	.o	1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpati	ent 3 DOA Oth	her: 4 Nursing Ho	me 5 🄀 Resi	idence	6 □Other (Spec	ifv)	

Division or Vital Re To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number D24543 29d. Date signed (Month, Day, Year) July 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Rossi, MD

3305 N. Leisure World Blvd., Silver Spring, MD 20906

State Registrar

Certification:

31. Date filed (Month, Day, Year) JUL 14 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6:45 A M Ubaldina F. Simmons 10 2008 /Medical July4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7744 Mandan Road Greenbelt Prince George's 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F Director 98 580-05-5789 March 31, 1910 Virgin Island Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iral", or Items 23a or 20770 U.S. 7744 Mandan Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married ☐Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Specify þ 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Post Master Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Christian Francis Maria Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Eldra Simmons / Daughter 7744 Mandan Rd., Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 22, 2008 St. John, Virgin Isla Cruz Bay Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licens Sonne 7400 Georgia Ave., N.W. Washington, D.C. 23a. Part1 Eher the disease, or complications the clased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Nutritional Deficiency /Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Examine law requires that the death certificate be executed Severe Alzheimer's Disease and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Sacral Decubitus Ulcer 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 □ Nursing Home 5 🙀 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or within 24 hours aff To the Funeral D

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

William J. Crittenden

14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

egistrar's Signature

29c. License number

MD33588

III, M.D. 1160 Varnum St., N.E. Washington, D.C. 20017

29d, Date signed (Month, Day, Year)

July 11, 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 6:00 a M July 11, Dorothy Sislen 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Hebrew Home of Greater Washington Rockville Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Voar Months Hours Min 1 □ M 2 🕱 F Yrs Director 722-10-9789 June 10, 1924 District of Columbia Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Exactions and be notified at Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 6121 Montrose Road, #429 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No <u>م</u> Specify. 3 Nidowed 4 Divorced Specify. "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Nursing Assistant marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othany or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Samuel Witt Ruth Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Sislen - Son 2211 Richland Street, Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 Kemoval from State King David Memorial Gardens 07/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SCHEMI Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. signed by the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 2 □No 1 □ Yes E HO 1 ☐Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 within 24 hours area.

To the Funeral Director: After this a remainderly filled in by the funeral director. ٩ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) MON TROSE INESH M.D. 31. Date filed (Month, Day, Year)

JUL 14 32. Registrar's Signature State 2008 Registrar

08-05287 **Betty Thomas**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24236

	1- For State Certificate of Death Reg. No.
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
Nedical Examine	BETTY THOMAS July 9, 2008 1744 ftts 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Doctors Community Hospital Lanham Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or ForeignAI_ABAMA
Director	106-40-2925 1 M 2 X F 59 Yrs. Months Days Hours Min. FEB 11 1949 Foreign ALABAMA Country)
,	Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d. Inside City Limits
ow an	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show any datonce	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 13a or 28a-f sho notified at once	7730 STEEL RIDGE ROAD 36117 USA
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once and by Furneral Director	
or items 23	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after rral", niner	
2 hour "natu	Elementary/Secondary (0-12) College (1-4 or 5+)
5-0036 ed within 72 hour lygiene. other than "natt	1 yr ADMINISTRATIVE ASSISTANT PRIVATE
15-0036 filed within 72 I Hygiene. do other than '	
S agray a	
MD 21 d 2 should lth and Me 11 27 is ma numatic ev	LINDA SNOWDEN/SISTER 11041 BROOKLAND ROAD GLENN DALE, MARYLAND 20769
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, Pages 1 ar Department of He Important: If ite Injury or other tr	BRASSELL CEMETERY 7/19/2008 MONTGOMERY, AL
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility
	7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line. Between Onset and Dath Dath
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Acute asthma Due to (or as a consequence of):
	Sequentially list conditions, b
900	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Uisease or injury that initiated
ted nsit	events resulting in death) Last Due to (or as a consequence of):
760, icate be execute physician and the burial - truthe burial	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
688 ertif	
Box e death c	1 Yes 2 No 9 ✔ Unknown g Unknown
P.O. Be es that the de igned by the or detached for the detached for the by the	
S, P	Chronic obstructive lung disease; hypertensive
Records, P.(The law requires tha ficate has been signed , page 2 should be det	heart disease 24a. Was an autopsy findings available autopsy findings available prior to completion of cause of death?
tal Rec	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The list certificate lidirector, page	25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital:
of Vital Records, ng Physician: The law require. ther this certificate has been sineral director, page 2 should the	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
the fur	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No
Division of Spital or Attending Phours after death. neral Director: After I filled in by the funeral	2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2	
To the Hos within 24 hy To the Fun completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To con	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
920	Patricia Cran, ca-Polloleus O.C.M.E. July 10, 2008
MC	30. Name and address of person who completed cause of death (Item 23a) Detricing Appring Dellar ADD Appring Address Madical Functions 4141 Damp Street Religious MD 21201
	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008

			1 - For State Registrar			ertificate of	Death		g. No.	
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	Thelma M. Troutman					June	25, 2008	02:00 A
	Examin	er	4a. Facility Name (If not institution, given Julia Manor Nursing Hon				r Location of Death		4c. County of Dea	ith
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Washington 9. Bi	rthplace (State or Foreign
L	Director		-10 20 03 15	□M 200 F)4 Yrs.	Months Days	Hours Min.	June 21,		yland
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f eh	tor	Maryland Washing	ton	Hagerstown					1 Yes 2 □ No
	or 28:	Directo	10e. Street and Number 11813 Par	tridge Trail		10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23s	iral		10 W D 1 1		21742-	V		S.A. 14. Race - Am	oringe leading
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. It we declar than interiously as an injury or other traumatic event. It we declar that the interiously and once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	ite, etc.
2-0	72 hor	eted	15. Decedent's Ec (Specify only highest gra		16a. Dec	cedent's Usual Occup	pation during most of work	ina 1	6b. Kind of Business	
121	within ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) homer	ve kind of work done . DO NOT use retire maker	d)		•	
d 2	filed v Hygie ther t	e Co	17. Father's Name (First, Middle, Last)		HOHICE	Harci	18. Mother's Name		omemaker laiden Sumame)	
lan	lid be fental rked c	To B	Frank Rizer				Katie Smith			
Maryland 21215-0036	2 shou and N le ma		19a. Informant's Name/Relationship (7		19b. Ma	iling Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
€,	l and Health nm 27 her tr		Carol Troutman	daughter		attercup Drive	Hagen		Maryland	21740-
Baltimore,	nt of h		20a. Method of Disposition Burial 2 Cremation 3 C		cemetery, ci	position (Name of rematory or other pla rmorial Gardens	ce)		Oc. Location - City o	r rown, State
alti-	mit. P partme cortan injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Femeral Service Licen			22. Name and Addre	1	.,	A gre IATG	Tyland
ä	permi Depa Impo any ir		1. wholas	12:31		Durst Funeral	Home, 57 Fro	ost Ave., Fro	stburg, MD 2	21532
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not e	inter the mode of dyir	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	type-T	ins,02				Chisel and Death
П	Examiner			Due to (or as a						
		ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a	consequence of):	12 D	1 10 01 01			
	rtiticate be executed ng physician and i as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	Dime	こって、ス				
68760,	be ex ician burial		,	Due to (or as a	consequence of);					
687	ntiticate ing phys a as the	Medical		. d.						
Вох		_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		B Ectopic pregnanc	v		23d. Date of de	
O. E	0 0	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 1 9☐ Unknown		Other (specify)			Month	Day Year
P.O.	that the	/Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying cause gru	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires in sign uld be	ed by						1 ☐ Ye	s 2□No 3□F	Probably 4 Dunknown
900	law reas bec	Completed						24a. Was an		autopsy findings available completion of cause of
<u> </u>	The cate h	Сош						perform	ed? death?	s 2□No
Vita	sician certiti rector	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death			
o	Phys arthis aral di	.: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur	y 28b. Time	of 28c. Injur		me 5 ☐ Resider 28d. Describe ho	nce 6 Other (Sp w injury occurred	ecify)
ion	ath. r: Afte	atloi	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Ye <i>ar)</i> Injury		rk? Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely tilled in by the funeral director, page 2 should be detached.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, : . (Specify)	street, factory, office		28f. Location (Str City or Town,	eet and Number or F , State)	Rural Route Number,
_	spital		29a. Certifier 1 □ Certifying Ph	ysician: To the best o	f my knowledge, de	ath occurred at the ti	me, date and place.	and due to the ca	use(s) and manner a	as stated.
	the Ho in 24 the Ful pletely	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner state	examination and/or	investigation, in my o	ppinion, death occurr	red at the time, da	ite and place, and du	e to the cause(s)
		Σ	29b. Signature and title of certifier	muhun		29c. Licens			d. Date signed (Mor	
	3		7			170	60396		06/2	> /0 %
	nes		30. Name and address of person who	completed cause of de			26 0		Mn 3	1740
	Sta	_	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1 4	110 845	1		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} ESTELL LEE TURNER JUL 2 2008 2:44 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 8. Date of Birth (Month, Day, Y March 14, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1∰M 2□F 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months California 1965 43 400-13-0065 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must he mast he matter. Once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County XXYes 2 □ No SD Sioux Falls Minnehaha Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 57105 USA 2405 S. West Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes 2 No 2888 Baltimore, Maryland 21215-0036 Specify: White 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army 12 Soldier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gloria White Clarence Estell Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2405 S. West Ave. Sioux Falls, SD Leah Ann Turner/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 7/11/08 4 □ Donation 5 □ Other (Specify) Camp Nelson National Cem. Nicholasville, KY 21. Signature of Fun Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 a Service Louisee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Blast Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ∀es 2 □ No 24a. Was an autopsy performed 2 \ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 XYes 2 □ No JUN 28 2008 9:00 within 24 hours after death. 2 Accident DURING MILITARY OPERATIONS 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BATTLEFIELD AFGHANISTAN 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Completely** and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 3, zod 0101054497 (VA) M ARMED FORCES INSTITUTE OF PATHOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH A. ROUSE LtCo1 MC USAF 20850 1413 RESEARCH BLVD., ROCKVILLE MD 31. Date filed (Month, Day, JUL 1 6 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24240 Certificate of Death Rea. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2008 6:25 Douglas Wilcox Waugh July 10, D /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Casey House, Montgomery Hospice Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** Hours 1 M 2 □ F Director SEP 8, 1934 Washington DC 578-44-4815 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4082 Norbeck Square Drive 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Mayes 2 No 1956− If Yes, Give Year or Dates: 1964 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If Item 27 is marked other th jury or other traumatic event, Ins 4 Systems Analyst TRM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick V. Wilcox Waugh Irma ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce G. Waugh / wife 4082 Norbeck Square Dr., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 07/12/2008 Tucson, Arizona 4 Donation 5 ☐ Other (Specify) Life Legacy Foundation 22 Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 20910
Approximate 21. Signature of Funeral Service Licenses M00956 Approximate Interval Between Onset and Death 23a. Part 1. Let the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner HYPERCOAGULABLE STATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed ATRIAL FIBRILLATION and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Day Ye ar in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 XNo 1 ☐ Yes 2X No 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) FACILITY Hospital: 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: To the Hospital or Attending Phys
) within 24 hours after death.

To the Funeral Director: After this
C completely filled in by the funeral dii 10+1

> State Registrar

Medical

29a. Certifier

29b. Signature

31. Date filed (Month, Day, Year) 14 JUL

and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

JULY 11, 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician George Hauer Zouck, July 10, 2008 3:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 3 M 2 □ F Director 115-01-6440 92 May_20, 1916 New Jersey Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8409 Hartford Avenue 20910 Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ ★es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after 1 □ Xes 2 □ No If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Food Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ George Hauer Zouck, Sr. Janet Electa Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Department of Health au Important: If Item 27 Is any injury or other trau once. Beatrice Burk Zouck/ Wife 8409 Hartford Avenue, Silver Spring, MD 20910 altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Fort Lincoln Cemetery July 16 2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20001 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) be executed burial-transit Aspiration Pneumonia and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical Failure To Thrive the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) ed by the detached f Ö 9 Unknown 9 Unknown σ, signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Cardiomyopathy, Left Lung Collapse, Atrial Fibrillation ficate has been si r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1 □ Yes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division or Attending 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a, Certifier 🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ٥ D64478 July 11, 2008 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Fisehatson Mehari, Md 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 14 JUL Registrar 2008

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:05^{am} Evelyn Austin 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Future Care Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2√□ F Director MD 212-14-1766 Usual Residence of Decedent 4-23-1913 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Director N/A MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21202 927 Webb Court permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event and any injury or other event and any injury or Funeral SA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ▼ No Specify. Specify. \$ Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 6th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Samuel M. Jones Mary ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 N. Aisquith Street Balto, MD 21202 <u>Gloria E. Bullock-Daughter</u> 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2008 Randallstown, King Memorial Pk 22. Name and Address of Facility Signature of Funeral Service Licensee March F/H East endiae 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 1 □Yes 2 □No detached 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 nknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2000 certificate 1 ☐ Yes 1 ☐ Yes After this certification, properties of the transfer of the tr 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 1 | Yes 2 | **3**00 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No hours after death. investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Than bon MI) 0 570 88 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Than Boon, 3d, 57. Comp. R Plan #601 31. Date filed (Month, Day, Year) Registrar's Signature State 1 Of Sand 9 Registrar

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			1 - For State Registrar	Otate of Warytan	·	te of Death	Reg. No.		24244
	اللاورية		Decedent's Name (First, Middle, Last)				2. Date of Death Month Day		3. Time of Death
	Physicia Medic		Ruth E. E	Bunch			July 19, a	2008	3 4
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7	F	di)	5. Social Security Number 6. Sex	ng & Kehab. L	enter (Tyear If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Bjrtt	nplace (State or Foreign
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	r 28a-	Irect	10e. Street and Number		10f. Z	p Code	10g. Citi	izen of What Co	untry?
	th witi	Funeral Director	5405 Summe	orfield A	ve.	21206		USF	}
	tems	une	Tr. Walter States	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	 Race - Ame Black, White 	
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	filed v Hygie other t		17. Father's Name (First, Middle, Last)		1/155emb	18. Mother's Nar	ne (First, Middle, Maiden	Sumame)	raciony
an	lental ked o	To Be	George Ar	thony		Pana	lora W	hite.	
Maryland	and Nand Is man		19a. Informant's Name/Relationship (Ty)	pe, Print) (Son)	19b. Mailing Addres	s (Street and Number or Ru	ıral Route Number, City o	r Town, State, Z	Zip Code)
-	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-1 ehow other traumatic event, the Madical Exeminar must be mailified at	1	Mr. King David	Anthony	5405 Place of Disposition (Na	Summerfi	Date 20c. Lo	ocation - City or	Md. 212.06
nor	Pages nent of H int: If Ite		20a. Method of Dieposition 1 ■ Burial 2 □ Cremation 3 □ R	, , , , , , , , , , , , , , , , , , ,	cemetery, crematory or	other place)	12000 D	and a	K MA
Baltimore,	글 문문을 .		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	3e ()	/ _22. Name,	Ind Address of Facility	-	unada	1, 1114.
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4 6			23a. Parti. Enter the disease, or complies shock, or heart failure. List only on	cations that caused the deal	th. Do not enter the mo	de of dying, such as cardia	or respiratory arrest,		Approximate Interval Belween Onset and Death
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medical Examinate)	ner: On the basis of examination and manner stated.	ation and/or investigation	n, in my opinion, death occ	urred at the time, date an	d place, and due	e to the cause(s)
	To ti To ti comp	Σ	29b. Signature and title of certifier		2	9c. License number	29d. Da	ate signed (Moni	th, Day, Year)
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	1		30. Name and address of person who co	mpleted cause of death (Item	m 23a) (Type, Print)	64493 Etheet, D	Minion	o Mi	02/201
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Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN BREWSTER D.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

PEWSTER D.D.
Year) 32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** July 26 2008 Carroll /Medical Brimer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cent NO-Fhuset er 1 Year | If Under 24 Hrs. 1-Kusa-K-1 Bottimera 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min 1 M 2 □ F 487-30-0834 Missouri Director 76 July 12 1432 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 217 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 154 W Chestnut Hill Lane 21136 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Logistics Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Pau1 Τ. Abbie D. Daniel Brimer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6417 Yaupon Drive Austin, TX Richard C. Brimer 78759 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation Ser 7/28/08 Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Sle Lin ren Eline Funeral Home Reisterstown, MD <u> 21136</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE MYGGORANII disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Corneryonely Fischemic Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 ☐ Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1_Inpatient 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No | Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

within 24 hours a

State Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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and manner stated

2. Registrar's Signature

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29c. License number

29085

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year MARY C. BALLARD 9135AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL GOOD SAMARITAN BALTIMORE N/A | Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months 216 56 3495 87 MAY16,1921 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 E. BIDDLE ST 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify. Specify: BLACK 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> 12TH</u> HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN MARGARET TATE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE CONLEY SR. (grandsoh) 2836 PROFITT PATH, EDGEWOOD, MD. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date JULY 31,2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) Baltimore National Cem Balto, Md Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Due to (or as a consequence of): PNEUMONIA, UTI ASPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESOOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A completely filled in by the fu State

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, it is I Musical Evanings must be notified at once.

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Baltimore, Maryland 21215-0036

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Registrar

PRACHI JOG, MD 31. Date filed (Month, Day, Year)

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32. Rajistrar's Signature

GOOD SAMARITAN HOSPITAL, BALTIMORE MD 21239

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Division of Vital Records, and or Attending Physician: The law requints after death all Director: After this certificate has been sited in by the funeral director, page 2 should be a sho	٦	27. Manner of Death		28a. Date (Month	of Injury Day,Year)	28b. Time of	Injury 2	_	ry at Worl	_	28d. Describ	e how injury	y occurred	
trendi death stor:	Certification:		ending vestigation						Yes 2			(0)1	d Niverbarrar	Dural Pouto Number City
lor A after Direct din by	₽		ould not be etermined		e of Injury - At I	home, farm, str	eet, factory,	office b	building, e	etc.	or Town,		number or	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		4 Homicide		(Specify)	t of my be made	dge, death occ	urrad at the	timo di	ate and ni	lace and	tue to the ca	use(s) and	manner as s	tated.
To the Hos within 24 h	Medical	(Check only one) 2 Medical I	xaminer:O	the basis	of examination	and/or investig	ation, in my	opinior	ate and pr	ccurred at	the time, da	e and plac	e, and due to	the cause(s)
To the within To the comple	Mec	29b. Signature and title of cer	an	d manner s	tated.				se number					Month, Day, Year)
		Calina	11	>/				O.C.	M.E.			July :	23, 2008	
Acid		30. Name and address of per	son who com	pleted caus	se of death (Ite									
Ot-bc.		Zabiullah Ali, M.D.		- 3	al Examine		nn Stree	t, Ball	timore,	MD 212	201			
Sta		31. Date filed (Month, Day, Ye JUL 2 \$	ar) 2008	140	egistrar's Signa	ature	1000							
Registr	εľ	JUL 2 9	, 2000	A POLICE	بار مرتان	No. of Street	- Color							-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 26 6:35 Corrick July Michael D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Golden Living Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APR 24 1963 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex. 1⊈M 2□F Mary Land 212-47-2025 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinations that the notified a 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 658 Lucabaugh Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Erran Int. Ang. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 🖸 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telemarketer Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keefer D. Corrick Joanne Faucet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Lobbins - sister 2609 Daisey Avenue, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7.28.08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²Chame and Address of Facility Cremation Society of Maryland, Inc. Dec 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. relanoma Immediate Cause (Final Tali **Physician** nan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Examine Day to for as a consequence off. The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 1 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 ☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

0 State Registrar 29b. \$ignature and t

31. Date filed (Month, Day,

e of certifier

1A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

43

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05675 2008 24251 State of Maryland / Department of Health and Mental Hygiene Ronald Douglas Canapp Certificate of Death Reg. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 24, 2008 1254 hrs Merical Examiner Ronald Douglas Canapp 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University of Maryland Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funera Months 213-31-8156 Director X_{M} 17 Oct. 24, 1990 Maryland 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 XNo MD Baltimore Lansdowne 28a-f show other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once, Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2924 Charleston Avenue 21227 United States Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Divorced If Yes, Give Year Yes 2 X No specify: Specify: Widowed White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours.
near of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Student Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeremiah Joseph Merath marked Jessica Rae Canapp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . 2 Jerry Merath - Father 2924 Charleston Avenue, Lansdowne, MD 21227 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, torx or other place) Cross Cemetery Horing Cremation 3 Removal from State Department of Important: 1 7-30-2008 Brooklyn, MD Other Spe Ambrose Funeral Home, Inc. 22. Name and Address of Facility of Funeral Ser 1328 Sulphur Spring Rd., Arbutus, MD 21227 cations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Part I. Enter the disease, or compli Between Onset and failure. List only one cause on each line 'Medical Death a. Blunt Force Head Trauma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED 23d. Date of delivery IF FEMALE: tending phy: use as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed of Vital Records, has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes No page ✓ Yes 2 CIVISION Of Vital R. To the Hospital or Attending Physician: Th within 24 hours after death.
To the Funneral To 26 Place of Death (Check only one) 25. Was case referred to medica funeral director Be Other₄ examiner? Hospital: 1 🗸 Inpatient Nursing Home 5 Residence 6 ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Manner of Death Certification: Driver dirt bike tractor trailor collision Jul 24, 2008 Natural 1223 hrs Yes 2 V No neral Director: filled in by the f Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 2200 Hollins Ferry Road, Baltimore, MD Suicide determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 25, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day Ye 2008

OCME

32. Registrar's Signature

			1 - State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryland		artment of l rtificate of			Reg. No.	2008	24252
W.	Physic /Medi Exami	cal	ELEANOR 4a. Facility Name (If not institution, give	CHICHESTER		4b. City, Town,	or Location of De		Day 6, 21	Year 008 County of Death	3. Time of Death 7:00P
	Funeral		FT. WASHINGTON HEA	LTH & REHAB			SHINGTON	V		RINCE GEO	ace (State or Foreign
	Director wou		Usual Residence of Decedent 10a. State 10b. County	10c. City,		cation		APRIL	24,		H CAROLINA Od. Inside City Limits
	ath with the Marylan 23a or 28a-f show	Funeral Director	MD PRINCE GE 10e. Street and Number 12021 LIVINGSTON F		. WAS	HINGTON 10f. Zip Code 20744			-	zen of What Coun	•
980	after dea or items	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:				(Specify Yes or No lerto Rican, etc.)	-	14. Race - Americ Black, White, e	an Indian,
21215-0036	-	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done OO NOT use retire	during most of v		16b. Kir	nd of Business/Inc	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy Injury or other traumatic event, traw once.	To Be	17. Father's Name (First, Middle, Last) JOHN W. THOMAS 19a. Informant's Name/Relationship (7)	ima Print)	10b Mailir	ag Addrage (Street	NANCY	Name (First, Middle, THOMAS			Oute
	s 1 and 2 s of Health ar item 27 is other trau		NANCY R. WILEY/NIE	CE 20b. Plac	708 3		S.E. WA	ASHINGTON Date	, D.C)
Baltimore,	permit. Pages Department of I Important: If ite any Injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	FT. I	LINCO	LN CEMETI	ERY 8/2	2/08 CAPITOL MO	BREN DRTI 14	NTWOOD, N	<u>1</u> D
8760,	The law requires that the death certificate be executed The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent) Due to (or as a consequent) Due to (or as a consequent) Due to (or as a consequent)	not ent	er the mode of dyi	ing, such as card	E., N.E. V	rrest,		Approximate Interval Between Onset and Death
.O. Box 6	at the death certific by the attending p tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnand Other (specify)	су		2	23d. Date of delive Month	ery Day Year
ords, P.	w requires that been signed I should be det	5	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the ur	nderlying cause gi	ven in Part I.				ne cause of death?
of Vital Records,	ician: The law certificate has b ector, page 2 sh	Completed	25. Was case referred to medical					1 □ Yes	rmed? 2012 No	24b. Were autoprior to cordeath?	psy findings available inpletion of cause of 2 1200
<u> </u>	hysician; this certific al director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EP	VOutnatien	t 3 DDOA Oth		Death <i>(Check only o</i> g Home 5 ☐ Resid		COthor (Caralle	
0	ng Ph ter th neral	ü	27. Manner of Death		Bb. Time of Injury	28c. Inju		28d. Describe t			<u> </u>
Division	To the Hospital or Attending Physician: within 24 hours after death. This certific To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	N⊈Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		M 1□	Yes 2 No	28f. Location (3 City or Tov	Street and vn, State)	d Number or Rura)	l Route Number,
	the Hospital thin 24 hours of the Funeral I mpletely filled	Medical	one) 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death	estigation, in my	opinion, death o	ccurred at the time,	date and	place, and due to	the cause(s)
	wit To wit		7/10.0	M·O	20) /7:		Se number S 3 6 -			e signed (Month,	
	Sta		30. Name and address of person who con the control of the control		INGST		T. WASH	INGTON, M	D.	20744	
	Registr		1111 2 9 2008	Rea le	7 7 7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Nº a					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macifcal Evaminat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit ysician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, <

	10	To the Hospital or Attending Ph within 24 hours after death.
D.	X	To the Funeral Director: After th
	1	completely filled in by the funeral

	For State Registrar	Cert	ificate of L	Death	Reg	No. 2008	5 24	253
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Occa Year	3. Time of	Death
an al	Norman Gladden Coe Jr.				July 26	2008 Page 2008	9:08	Ам
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat		
	St. Joseph Medical Center		Towson			Baltimore		
	5. Social Security Number 6. Sex 7. Age (In yrs. ld 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		If Under 1 Year Months Days	Hours Min.	8. Date of Birth Apr. 29,	9. Birt	hplace (State of Mary	land
	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loca	ation				10d. Inside Cit	v Limits
ō							1 □Yes	
ect	MD Baltimore Tows 10e. Street and Number	on	10f. Zip Code		100	. Citizen of What Co		^
Be Completed by Funeral Director	802 Hatherleigh Road		21212		"	ISA		
nue	11. Marital Status 12. Was Decedent Ever in U.8 Armed Forces?	5. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto l	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
d by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1[□Yes 2MiNo	Specify:		Specify:	white	
ete	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupa ind of work done o	luring most of workii		b. Kind of Business/	Industry	
μ	Elementary/Secondary (0-12) College (1-4or 5+)	_	O NOT use retired)	Da	int Contr	actor	
ပိ	12 17. Father's Name (First, Middle, Last)	Owner		18. Mother's Name			actor	
To Be	Norman Gladden Coe Sr.			Pauline (,		
_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Rura	il Route Number, (City or Town, State, .	Zip Code)	
	Cecilia D. Coe / wife	802 Ha	atherleig	gh Road; [*]	Towson, N	ND 21212		
	20a. Method of Disposition 20b. P	lace of Disposi emetery, crema	tion (Name of atory or other plac	e) D	ate 20	c. Location - City or	Town, State	
	1 Burial 2 Literation 3 Li Hemoval from State	-		rp. 7/31/	′08 Т	owson, MD		
	21. Signature of Funeral Service Licenses		Name and Addres			1050 York		
	The way	Ruc	ck Towson	n Funeral	Home	Towson, N	1D 21204	-
	23a. Part 1. Enter the disease, or complications that of used the death shock, or heart failure. List only one cause on each line.	n. Do not enter	the mode of dyin	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Bet	ween
	Immediate Cause (Final disease or condition	sclera	otic Co	ndwaso	ular DI	sease	Onset and I	Jeath
	Due to (or as a consequ	uence of):				10.		
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	uence of):						
Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	,						
Exa	resulting in death) Last Due to (or as a consequence)	uence of):						
ical	L d							
/led	IF FEMALE:							
	23b. Was decedent pregnant 23c. If yes, outcome of pregna		Ectopic pregnanc	v		23d. Date of de		V 0 0 F
Completed by Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of d 9 □ Unknown		Other (specify) _	,		Month	Day	Year
y Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the und	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of c	leath?
ed b					1 □ Yes	2 □ No 3 □ F	robably 4	Jnknown
plet					24a. Was an autopsy	24b. Were a	utopsy findings completion of c	available
ΜÓ					perform	ed? death? XNo 1 □ Ye	~	
Be (25. Was case referred to medical examiner?			26. Place of Death	h (Check only one,			
	Yes 2 No Hospital: 1 Inpatient 2 N	ER/Outpatient		4 Li Nursing Ho		ice 6 ☐ Other (Sp	ecify)	
on:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe hov	injury occurred		
cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2□No	20/ 1 - 1/ 10		15	
ertifi	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specif.	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	lural Houte Nun	nber,
ğ	29a. Certifier 1 ☐ Certifying Physician: To the best of my kno							-
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or inv						5)
2	29b. Signature and title of certifier		29c. Licens			d. Date signed (Mon		_
,	theyeltated IVW be puty		018	661	1	uly 28	,2008	5
1	30-Name and address of person who completed cause of death (ken Ph.: PM: Lip M: Lipello MD C	23a) (Type, P	ble H:1	ICT. Lut	-herville	Md 210	993	
te	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	2			1'		
ar	JUL 2 9 2008 Deser 10	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 10c per the 881 7-29-08 vt

	for State Registrar	State of Marylan	a / Department (Certificate	of Health and I of Death		Reg. No.	8 24255
Physician	1. Decedent's Name (First, Middle, L	ast)	CARTE	R	2. Date of Dea Month	Day Yea	3. Time of Death
/Medical	42 Equility Name (If not implication a	ive street and number)		wn, or Location of Death	JULY	4c. County of De	<u> </u>
	The Johns Hopkins			ore City		N/A	
Funeral Director	213 70 1480	Sex 7. Age (In yrs. I	/ast birthday) If Under 1 Yrs. Months [Year If Under 24 Hrs. Days Hours Min.	8. Date of Birtl	1 ^{yea} /1971	Birthplace (State or Foreign Country) MD
show dat	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	DATEMORE			10d. Inside City Limits
e Maryla Ba-f sho iffied at	MD N/A		2229 E. C	BALTIMORE	-		X☐ Yes 2☐ No
be filed within 72 hours after death with the Maryland tial Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at the Completed by Eunaral Director	10e. Street and Number 2229 E. Chase	e St.	10f. Zip-Co	21213		10g. Citizen of What (USA	
items ler mu	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Deceder If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.
hours after tural", or ite al Examiner	3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀	No Specify:		Specify BI	ACK
21215-0036 ed within 72 hours aft ggiene. her than "natural", or her than Medical Examin t, the Medical Examin	15. Decedent's (Specify only highest of		16a. Decedent's Usual C (Give kind of work	done during most of wor	rking	16b. Kind of Busine	ss/industry
YIANG 21215- Und be filed within 72 Mental Hygiene. arked other than "nat atic event, the Medica	Elementary/Secondary (0-12)	College (1-4 or 5+)	NURSING	ŕ		LORIEN	Nursing Hm.
be filed tal Hyg d other event, t	17. Father's Name (First, Middle, Las	•	,	18. Mother's Na		Maiden Surname)	
	2 JAMES V. Cal		1401 44 11 44 4 4 4 4		Jones		7: 0.11
and 2 sh and 2 sh ealth and n 27 is n er traum	19a. Informant's Name/Relationship Carolyn Brown		19b. Mailing Address (\$ 3343 Rave				
4 5 E E	20a. Method of Disposition 1 ☐ Burial ★☆ Cremation 3	☐ Removal from State	3343 Rave	of July	Date 29,20	20c. Location - City	or Town, State
baltimore permit. Pages to Department of H Important: If Ite any Injury or ot	4 Dopation 5 Other (Special Signature of Funeral Service Lice	cify) GR	22. Name and	Address of Facility 1 B. Scrug	I I	DALIO, P.	
Ben Den O	Blinading	1 ochurs	1412 F	Prestor	st. B	alto.Md.	
122/22	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	v one cause on each line.					Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. FCQUITE d Due to (or as a consequ	IMMURE uence of:	DERCIEN	CO 11	.705	1
Examiner	- Sequentially list conditions	b					
xecuted and al-transit	Sequentially list conditions, if any leading to him of the cause. Enter Underlying Cause (Disease or injury that initiated events	. Dasé to (or as a consequ	tianos oty				
	resulting in death) Last	c. Due to (or as a consequence	uence of):				
ifficate be e g physiciar as the bur		d					
certific certific use as		23c. If yes, outcome of pregna	ancy			23d. Date of	delivery
death death deformed form	in the past 12 months? 1 □ Yes 2 ☒No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown				Month	Day Year
requires that the een signed by the hould be detache			sulting in the underlying ca	use given in Part I	23e Did to	obacco use contribut	e to the cause of death?
dS, lires th signed Id be d		out the country of the country of the country of	and an and and anymy da	ado given in rain i.	1 🗆 `		Probably 4 Unknown
The law requires to the law requires to the has been signed page 2 should be completed by					24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
The la ate has page					perfo	rmed? deat 2⊠No 1 □	1?
OT VICAL Physiclen: T this certificate and director, pa	examiner?	Hospital: 1 🗷 Inpatient 2 🗆	ER/Outpatient 3 □ DOA	Other:	ath <i>(Check only of</i>		accital.
g Physi g Physi er this o heral dir	OT M / D	28a. Date of Injury (Month, Day Year)		Injury at Work?		now injury occurred	эвспу)
Attending at death. sector: After by the fune	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion	М	1 Yes 2 No			
UNISION (tal or Attending P rs after death. el Director: After t led in by the funer.	4 Homicide determine		ome, farm, street, factory, o	ffice	28f. Location (City or Tow		r Rural Route Number,
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has I completely filled in by the funeral director, page 2		Physician: To the best of my kno raminer: On the basis of examina and manner stated.					
To the Comp	29b. Signature and title of certifier			icense number		29d. Date signed (M	
7	So Name i di	MA		ES-000)]	7017, 9	5,2008
2	30. Name and address of person when Tulia Beaut		m 23a) (Type, Print)	600	North Wo	olfe St, Baltin	more, MD, 21287
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	<i>*</i>			-
DHMH 17 Rev 1/2001	JOL 2	9 2008 Sugara	J. Speak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 26 Day 6:25 pm HAROLD GILLIS DAY 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MIDDLE RIVER BALTIMORE IVY HALL NURSING CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 2 / 1 9 / 1 9 1 5 5. Social Security Number Birthplace (State or Foreign Country) '. Age (In yrs. last birthday) 1 M 2 □ F 213074469 93 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo BALTIMORE MD ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 ROSEWICK AVE 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n SCARFER INSPECTOR STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRADLEY GILLIS DAY AMELIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 ROSEWICK AVE BALTIMORE, MD CLARA F. DAY/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 7/30/08 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1) 4001E Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlah-transit Box 68760, P.0. Division of Vital Records,

Physician

/Medical

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Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

27 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Widdon Evan, institut for routh of

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event.

Physician

/Medical

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

60 Ohh

29b. Signature and title of certifier

TertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave, Batimore, MD. 2122 1124 Mace

31. Date filed (Month, Day, Year) 32. Segistrar's Signature 2008

and manner stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear 9:29 P M JULY 23. 2008 TERESA A DAWSON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 03/12/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Min. 180-20-1 ☐ M 2 ☐ 8Ó Months Days Hours Yrs PA Usual Residence of Decedent 10b. County 10d, Inside City Limits 10c. City. Town or Location Frederick Frederick TX Yes 2□ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 USA 6351 Spring Ridge Parkway # 333 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 🗷 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 XNo Specify Specify 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Volpe Patella Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10904 Farrier Road, Frederick, MD 21701 19a. Informant's Name/Relationship (Type. Print) Albert E. Dawson, Jr. / Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Penn Lincoln Memorial 07/28/2008
Park 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State North Huntingdon, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 Mars Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Sepsis trom Due to (or as a consequence of): Dronory IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Mudical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

death with the Maryland

Examiner

Physician/Medical 2 Completed Be

attending physician as the ģ signed I has certificate 24 hours after deat Funeral Director; filled in by the

Division of Vital Records, P.O. Box 68760,

Certification: To

8

within 2 To the

State Registrar

Medical

29a. Certifier

(Check only

27. Manner of Death 1 Natural 5 Pending

investigation 2 Accident 6 □Could not be 3 Suicide 4 Homicide

9

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number MDD 66166

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

erZer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raza Severth St, Frederick, 400 31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 24259 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 1315 hrs July 22, 2008 Medical Examiner Clarence Davis 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 1222 Bloomingdale Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min Months Days Hours Director 250-13-2766 6-5-1957 $_{1}X_{M}$ 50 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County IOc. City, Town or Location any 1 X Yes 2 No 23a or 28a-f show notified at once. MD N/A Baltimore death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code 1222 Bloomingdale RD 21216 U S Α 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12, Was Decedent Ever in U.S. 11. Marital Status ıral", or items 2 niner must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 4X Divorced Specify: Black Yes 2 X No specify: Yes, Give Yea hours after Widowed "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ it. Pages I and 2 should be filed within 72 l rtment of Health and Mental Hygiene. rrtant: If item 27 is marked other than "I y or other traumatic event, the Medical I 21215-0036 12th grade Laborer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Davis, Jr Rosalie Terry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Glade Court Brooklyn, Grenda Taylor-Sister MD 20c. Location - City or Town, State Charleston, S.G. Charlestown, S.G. Moncks Corner 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition Palmetto Creme Society 2 X Cremation 3 -14-08 1 Burial Removal from State portant: Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East North Avenue Balto, MD 21202 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. 'Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease ≀aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, perME, g882, 8/8/08/TT WS ysician a burial -X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours affect death.

Thin is the Function Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buria Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✔ Yes No No Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 V Other: Scene 2 ER/Outpatient 3 Inpatient 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number July 23, 2008 O.C.M.E. 01 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** liza 2008 July DOCIS 9 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Edgewood tord asonia OUY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🗹 F Yrs Feb 27, 1924 Maryland 216-20-7282 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Funeral Director dgewoo Of. Zip Code 10g. Citizen of What Country? 10e Street and Number 14. Race - American Indian Lasonia 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 □ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sears eiving ilerk 16. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hugust Dougherty

19a. Informant's Name/Relationship (Type. Print) Doughter ဥ rame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strozykowsk Edgen 6 Lasonia Court MD sood 21040 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 7-19-2008 Forest Hill, Maryland

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 3 Newport Drive Forest HU 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Una /Medical Due to (or as a considence of): Examiner JV Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a) a consequence of): Examiner be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical tensi as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) n signed by the ar P.O. I 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe Yes 2D 10 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl on Other: 4 Nursing Home ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mayiner of 28b. Time of Certification: or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No ☐ Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as dates.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person and completed cause of death (Item 23a) (Type, Print) Old Emmorton MD 22 2 Day, Year) 31. Date filed (Month egistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 25 2008 July 1:30 Ralph Ernest Davis 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Year) May 10,1926 9. Birthplace (State or Foreign Country) Delaware 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex Months Days Hours Min. 1 M 2 □ F 222-10-6886 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County 1 □Yes 2 No Marylahd Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 21093 USA Pot Spring Road S-509 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housina Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Rebecca Ellis Samuel Herman Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Philadelphia, Pa. 19147 Arthur Willson / Nephew 728 Passyunk Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop ServiceCorp.7/28/08 Towson, Maryland 21. Signatur Funer Province 22. Name and Address of Facility 1050 York Ruck Towson Funeral Home, Inc. Towson.md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Priform Monl MAMO arcinome disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part IL-Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2.DNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exant inner must be notified at

Maryland 21215-0036

Baltimore,

be executed and burial-1 physician the as attending nse s for the signed by t peen (has

Box 68760. P.0. Division of Vital Records, director, page 2 should certificate Hospital or Attending Physician: this funeral After death. Funeral Director; fletely filled in by the fi hours after

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Physician/Medical IF FEMALE: ģ Completed Be 27. Manner of Death Natural 2 Accident

Certification: To 29a. Certifier Medical

ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year) State Registrar

3 Suicide

4 Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

5 Pending investigation

6 Could not be determined

2300 DULANEY VALLEY ROAD 32. Registrar's Signature

TIMONIUM MD

21093

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** July 25 2008 7:35 P Doris Lee Diggs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country)
WEST VIRG. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours Min. 1 □ M 2 🗹 F 62 579-64-0652 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Frederick BARTONSVILLE 1 ☑ Yes 2 ☐ No Director MD. FREDERICK 10e. Street and Number 10g. Citizen of What Country? 21704 5912 BARTONSVILLE USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑No Specify: BLACK Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARTER CELENA ROPER BENJAMIN F. 19a. Informant's Name/Relationship (Type. Print) (405) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 BARTONSVILLE RD. FREDERICK MO 21704 CHARLES W. DIGGS SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN MON. GAR, JULY 31, 2008 FRED. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility 6 ARY L. ROLLING FULL Itant sew a. NO WEST SOUTH ST FREOBRICH MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Sepsis undetermined Trom disease or condition resulting in death) Due to (or as a consequence of): months Pancreati ance if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Of

Funeral

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28a-f show

r than "natural", or items 23a or 28a-f show

Hygiene. other than "natural", or

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Important: If Item 27 Is
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Physician

/Medical

Examiner

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attending p

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has page 2

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After

within 24 hours after death

To the Funeral Director:
completely filled in by the

hours after death.

Hospital

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funeral

Maryland 21215-0036

Baltimore,

O. Box 68760,

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of Vital Records,

Division or Attending

> State Registrar

DHMH 17 Rev 1/2001

Mydusar 31. Date filed (Month, Day, Year) JUL 2 9 2008

Kaza

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 WEST Raza 32. Registrar's Signature

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FREDERICA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienea O O O

		1	For State Registrar		otato or ma	, y laira ,	Cert	ificate of)		leg. No	2000	242	b 3
Phys /Me	iciar dica		1. Decedent's Name (First,	Middle, Las	Drus	ч					Date of Dear Month	th Da	y 2008	3. Time of De	
Exar		r	ta. Facility Name (If not insi			0/00	ind an	4b. City, Town, o	r Location	of Death	- 1	40	County of Dear	th	
Funer Direct			5. Social Security Number 214-14-1647	1		(In yrs. last b	pirthday) Yrs.	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. 8. I	Date of Birth Month, Day 1/30/19) Year)	9. Bir	thplace (State or Fountry)	Foreign
yland	0		Usual Residence of Decede 10a. State 10b. C			10c. City, To	wn or Loca	ition						10d. Inside City	Limits
ne Mar 18a-fsl		ector		imore		Timoniu	m					10 0		1 ☐ Yes 2	No No
ath with the 23e or 2		runeral Director	10e. Street and Number 405 Plumbridge	Court	Unit 201			10f. Zip Code 21093				U.S	S.A.		
Dealtimore, Interfylating ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is merked other than "neturel", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar man be notified at		2	11. Marital Status 1 ☑ Never Married 2☐ 3 ☐ Widowed 4 ☐ Div		12. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		-	as Decedent of H Yes, specify Cuba □Yes 2 🛛 No	lispanic O an, Mexica Specify		Yes or No- in, etc.)		14. Race - Ame Black, Whit Specify:		
CID-C		Completed	15. Dec (Specify only Elementary/Secondary (0		ucation de completed) College (1-4or 5+	<u>, </u>	(Give ki life. D	nt's Usual Occup nd of work done O NOT use retired	durina mo	est of working			Kind of Business	/Industry	
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and 2 sho ealth and In 27 is merer traums	Ì		19a. Informant's Name/Relation Francis Drury,			4	05 Plu	Address (Street mbridge C	ourt U	Jnit 201,		ium,	MD 21093		
allillore rmit. Pages 1 partment of H portent; if iter			20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			20b. Place cement	od Cem			07/28/20		Balt	Location - City or Cimore, Ma		
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Physicia /Medic			23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or comp List only	olications that caused to one cause on each line a. Due to (or as a	aut	e N	the mode of dyin	ng, such a	as cardiac or re	spiratory ar	rest,		Approximate Interval Betwe Onset and De	een eath
Examine		_	Sequentially list conditions,	1	b. Due to (or as a										
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The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit		Priysician	23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnand Other <i>(specify)</i> _	су			Ì	23d. Date of de Month	Day Ye	ar
w requires that the despension of the should be detached	3	2	Part II. Other significant co	onditions c	ontributing to death bu	t not resulting	in the und	lerlying cause giv	ven in Part	t I.				o the cause of de	
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VILA /sicten s certifi lirector	2	l pe	25. Was case referred to m examiner? 1 ☐ Yes 2 ☐ No	edical	Hospital:	nt 2 DER/	Outnationt	3 □ DOA Oth	or:	ce of Death (C			6 ☐ Other (Sp	onify)	-
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or Attending Physicien: after death. Director, After this certification by the funeral director,		ermication:	2 ☐ Accident ii 3 ☐ Suicide 6 ☐ 0	nvestigation Could not be letermined		ry - At home, . (Specify)	farm, stree		Yes 2		Location (S			Rural Route Numb	er,
To the Hospital or Attending Physicien: The within 24 Hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	3	legical Ce			ysician: To the best on niner: On the basis of and manner sta	examination									
To the within To the comple	12	Me	29b. Signature and title of c	erther		V	بالر	29c. Licen	e number	474	_	29d. C	Date signed (Mor	oth, Day, Year)	
af.		1	30. Name and address of	rson who	completed cause of de	eath (Item 23a	a) Type, P	rint) XX 00	W V	ether	BUN	1	with	y. Md	24
Regi	State istra		31. Date filed (Month, Day,	Year) 2 9 2	32. Fegistra	r's Signature	A	ale				•			

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death with the Ma items 23a or iner must be n "natural", or iten filed within 72 hours after Hygiene. than permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic event, the 1 once. the

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Hospital or Attending Physician: The law requires that the death certificate be executed physician and burial-tra the signed by t certificate this After t Director: Funeral Director etely filled in by t

Division or Vital Records, P.O. Box 687605

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year 10:10/+M 2008 VIOLA 260 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 369 Townsend Road Essex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 218-18-8163 99 May 17, 1909 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No MD Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 369 Townsend Road 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles M. Adams Charlotte Rahley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 369 Townsend Road Essex, Maryland 21221 Mrs. Lenora D. King/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/30/2008 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. alter 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEBILITY MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 ☐Unknown ARTHRITI 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2₽Ño 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/21 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 062032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SSOS HOPKINS BYLVIEW CIRCLE BALTIMORE HMASH 1 h, Pay, Year) 32. Projetrar's Signature 31. Date filed (Month, Pay, State 9 2008

Registrar DHMH 17 Rev 1/2001

24 hours

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene glene Reg. No. 2008 24265 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\tilde{J}u^{\text{Month}}_{\boldsymbol{J}}$ 26 2008 9:45 a^{M} С. Erdman William 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 8. Date of Birth (Month, Day, Year) Oct. 05 1945 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours 1 M M 2 □ F Maryland 214-44-2961 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Kenilworth Drive 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Defense US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard C. Erdman Mary Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 Kenilworth Dr. Towson, Md. 21204 Mrs. Patricia Erdman/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Hilltop Service Co. 7-31-08 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 23a. Part1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTAGE ementica years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar use as ģ P.O. funeral director, page 2 should be det Division of Vital Records. After this

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be retified at

72 hours after

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Pages 1 and 2 Health a

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Important: If it any injury or

Physician

/Medical

Examiner

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Funeral Director

Be Completed by

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Examiner

Physician/Medical

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Be Completed

Medical Certification: To

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

Md.

within 24 hours after deatl To the Funeral Director: filled in by completely

31. Date filed (Month, Day, Year)

6 Could not be determined

29c. License number

Towsentown

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

环 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 MD 565 W

2. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** -5 2008 /Medical 4c. County of Death stitution, give street and number) wn, or Location of Death Examiner N/A Comove If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 29,1923 9. Birthplace (State or Foreign Country) Pennsboro, W. VA. Social Security Number 6. Sex Age (Ir rs. last birthday **Funeral** Months Days 1 M 2 □ F 85 Yrs 236-20-6039 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Maryland Baltimore Co. Baynesville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21234 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a, any injury or other traumatic event, the Medical Examiner must bonce. 1703 Wayne Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? INDUSTRIES AND IT Yes, Give Year or Dates: W • W • 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify W.W.II Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Electric Manufacturing Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Caroline Williamson Louis Thomas Freeland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baynesville, Maryland 1703 Wayne Ave. Mrs. Goldie E. Freeland (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State <u>ž</u>obs 29, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses PEaceful Afternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Party Enter the disease of shock, or heart failure Lie Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** /Medical Due to r as a consequence of) 3 KOHK Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner the burial-transit Due to (or as a consequence of): physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ★ Yo Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 ☐ Unknown signed by to significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2A'No 3 Probably 4 Unknown cate has been signage 2 should b 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 Yes 2 No the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

death v

Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

To the Hospital or Attending Physician: s after death. Within 24 hours are. _____
To the Funeral Director

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 MD

31. Date filed (Month, Day,

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** Clarence Russell Foster 10:00AM duli 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Hospital of Baltimore BaltiMORECITY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Sex 1 M 2 □ F **Funeral** Months Days Hours MD 212-30-9940 Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, I's. McJical Examinating to notified 1 TYes 2 No **Funeral Director** Baltimore Windsor Mill MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21244 USA 8413 Merryview Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1552-55 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Rlack White, etc. 1 Never Married 3 Married 1 ☐ Yes 2 No Specify: specifAfrican-American ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dundalk Marine Terminal Maintence Engineer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event. Be (Lillian Foster Moses Lindsey ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8413 Merryview Drive, Windsor Mill, MD 21244 Rosa Foster/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 7-30-08 GarrisonForest Veterans Owings Mills, MD 22. Name and Address of Facility Lie Funeral Ranc P.A. of Balto. Co. So the of Funeral/Service Licens 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscleroticheart disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pheval Vascular disease 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 2 No 1 □Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☑ Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this completely filled in by the funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

State Registrar 29b. Signature and title of certifier

Alejandro

To the within 2

Maryland 21215-0036

Baltimore,

P.O.

Division of Vital Records,

and manner stated.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ICIRA

Seg

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10024726

Sinai Hospital of Baltimore

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

P.O.

31. Date filed (Month, Day, Year)

		,	State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and Mertificate of Death		ne 2008 24271
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	/Media	cal		Griffin	7 2	26 2008 6:15 PM 4c. County of Death
-	Examin	er	4a. Facility Name (If not institution, give street and number) 3810 The Alameda	4b. City, Town, or Location of Death Balto		N/A
	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last birthday, Yrs.		8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country) VA
	70		Usual Residence of Decedent			10d. Inside City Limits
	f shov	ŏ	10a. State 10b. County 10c. City, Town or L			1 → Yes 2 □ No
	the N	Director	MD N/A Balto	O 10f. Zip Code	10g	. Citizen of What Country?
	h with	al D	3810 The Alameda	21218	1	J S A
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be routiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 ho I Hygiene. other than "natur ent, the Medical	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workii DO NOT use retired) Office Clerk	ng 16	b.Kind of Business/Industry Smith Dental Lab
Maryland 2	0 7 5	To Be Co	17. Father's Name (First, Middle, Last) James Albert Palmer	18. Mother's Name Rosa Gi		iden Surname)
	and 2 shoulaith and N			ing Address <i>(Street and Number or Rure</i> O The Alameda l		City or Town, State, Zip Code) MD 21218
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e <u>once</u> .		1 D Burial 2 I Cremation 3 I Removal from State	ematory or other place)		c. Location - City or Town, State
Balt	permit. Departi Import any Inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Market 1101 E. North	arch F/I Avenue	
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	iter the mode of dying, such as cardiac of	or respiratory arres	t, Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	The conditions of the conditio			
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as p	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ∐ Yes	cco use contribute to the cause of death? 2 □ o 3 □ Probably 4 □ Unknown
Vital Records,	ı clan: The law requ certificate has been ector, page 2 shoule	Completed			24a. Was an autopsy perform 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Vit		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatie	26. Place of Death	. /	0 TOhar (0 /)
		n: To	27 Manner of De th 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	ce 6 ☐ Other (Specify) r injury occurred
ion	ttending death. stor: Aft the fun	atio	1 Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	al or Attending s after death. al Director: After ed in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.		red at the time, dat	e and place, and due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifiar	29c. License number	296	d. Date signed (Month, Day, Year)
	5		30. Name and audress of person who completed cause of death (Item 23a) (Type 31. Date filed (Month Pay York) 32. Projector's Signature	gluno Barrien G	rue B	alprive MD
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature,	The state of the s	· · · · · · · · · · · · · · · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 24272 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Egan Groth 11:32A M Ju1v 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 110 M 2□ F 090-42-7348 Wantagh, N.Y. Director Jan.16,1951 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is merked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Co. Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 United States 1 Stone Gate Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 of Health and Mentel Hygiene. College (1-4or 5+) Self Employed Food & Beverage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Edward Groth Catherine M. Egan P Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gale Patricia Arden (Wife) 1 Stone Gate Court Pikesville, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If It any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State July 30, 2008 Dulaney Valley Mein. 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility acceful Alternatives Funeral & Cremation 325 York Road Timonium, Maryland 21 2325 23a. Party Enter the diseas shock, or heartyfailure Immediate Cause (Final Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician brovosce (ar acciden Y day 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tren resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day funeral 27. Manne eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 - atural 5 Pending investigation 1 Yes 2 No death. 2 ☐ Accident ofter death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours e To the Funeral I 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA Q. MR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21:00 M July 2008 moth /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTMORE Hospital BAUTIMOKE 7. Age (In vrs. last birthday) Funeral Min. Days Months 1 X M 2 □ F Hours Yrs 216-80-3588 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner near be notified at 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò or items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 N If Yes, Give/ Year or Dates: 1 ☐Yes 2 XNo Specify δ 3 Widowed 4 Divorced ack Health and Mental Hygiene. em 27 is marked other than "natural", Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 283 02 19a. Informant's Name/Relationship (Type. Print) (mother) Pages 1 and 2 permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once. ille North Carol 20c. Location - City or Town, State Carolin etteville Mrs. Louise ay Holland Baltimore, PATIENT 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 129/2008 Mount Cremetori 22. Name and Address of Eability
Joseph L. Russ Funeral Home, P.
2222 W. North Ave. Balto. Md. 21 21. Signature of Funeral Service 100 Tatelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypocycenic Due to (or as a consequence of): Encephal aparth disease or condition resulting in death) /Medical Examiner RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed SEPTIC Shock and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9 Hlnknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 W Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending after death Director: filled in by 24 hours a completely within 2

> State Registrar

Medical

29a. Certifier

(Check only one)

MICHAEL

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

MANTINAN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

SINA HOSPITAL OF BALDMOKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** 07 Hanna 2008 Delmar 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MAR 17 1918 Days Hours 1□M 2**X**F Maryland 90 217-07-1899 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 701 Maiden Choice Lane items 23a Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify: þ White 3 X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Pennsylvania Elementary/Secondary (0-12) College (1-4or 5+) other than Railroad Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I Lohr Wilhemina . Carrol1 M. Royston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a important; if item 27 is any injury or other trau 114 Waterside Court, Edgewater, MD John Hanna - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/30/2008 Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williams 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preu monia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed and Due to (or as a consequence of): physician s the burial Physician/Medical as attending 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Dysphagia Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b irector, page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 versing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funera 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bowlin

JUL 2 9 2008

DHMH 17 Rev 1/2001

within 24

29c. License number

1)44372

29d. Date signed (Month, Day, Year)

Lane, Catonsville, MD 21228

and manner stated.

711 Maiden

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physicia		1. Deceden	t's Name (Firs	st, Middle	e, Last)							2. Date of De		ay	J U O Year	3. Time of Death	ਹ
/Medic		LUCIL	LE MARG	ARET	HOLLOWAY							JULY 28			1 car	8:40 A M	
Examin	er		Name (If not i		, give street and	n <i>umber)</i>			4b. City, Town	BURNIE	n of Death		4c. County of Death ANNE ARUNDEL				
Funeral Director		5. Social Se	6.6040	r	6. Sex 1 □ M 2	7. Ag	e (In yrs. I	last birthday) Yrs.	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Bi (Month, D JAN 16,	ay, Yea	r) I	9. Birthp Coun	ace (State or Foreign try) MD	
and	- 1	Usual Resid	dence of Dece	County			10c. City	y, Town or Lo	cation						11	d. Inside City Limits	-
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h the	Director	MD 10e. Street	and Number	AIAE VI	KUNDEL		GLLI	DOMATE	10f. Zip Code	9			10g. (Citizen of	What Coun		\neg
23a c		108 A	RCHWOOD	AVE.					2106	1				US	A		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		Status ver Married		ied 1 □Y6	Forces?			Was Decedent of fYes, specify C 1 ☐ Yes 2 ☐ N			ecify Yes or No Rican, etc.)	0-		ce - Americ ck, White, e		
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Physician /Medical Examiner parish and prival-transit	Exa	shock, or heart failure. List only one cause on each line. Immediate (Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):															
To the Hospital or Attending Physician: The law requires that the death certificate be every within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 \overline{\text{VNo}} \ 9 Unknown											ery Day Year				
w requires that the de been signed by the a should be detached f	2	Part II. Othe	er significant		ons contributing to		ut not resu	ulting in the u	nderlying cause	given in Par	t I.			o use con 2 🗌 No	tribute to th	ne cause of death?	
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1 - For State Registrar

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For State Registrar		State of N	/laryland /	,			ealth a D <i>eath</i>	and M	iental Hy	ygier Reg. I		000) <u>^</u>	1070
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Thom	IAS C	. HE	RN	JR					Month 0 7		Day	Vear Q-5	142	LL M
4a. Facility Name (li	f not institution, give	street and number	er)		4b. City,	Town, or	Location	of Death			4c. Count	ty of Death	1	
1777	THE CHESAP				LINT			0.111			ANNE	ARUNDE		
 Social Security N 135.28.931 	- 10	M 20F 7.	Age (In yrs. last 72	birthday)_ Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D	Day, Ye	ar)	9. Birth	place (Stati intry) NJ	e or Foreign
Usual Residence of			10c. City, To	win or Lon	otion								10d. Inside	City Limite
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MD 10e. Street and Nur	ANNE AR	UNDEL	LINT	HICUM	10f. Zip	Codo				100	Citizen of	f What Cou		**
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THOMAS C.								EN OE						
19a. Informant's Na	ame/Relationship (7	ype. Print)	1	9b. Mailing	Address	(Street a	and Numb	er or Rur	ral Route Num	nber, Ci	ity or Tow	n, State, Z	(ip Code)	
DIANE ANDE	RSON	DA	UCHTER				N. AUS		X 78746					
20a. Method of Disp	position Cremation 303	Removal from Sta	ceme	e of Dispos etery, crem	ition (Nai atory or o	me of otherplac	e)	1	Date	200	. Location	n - City or	Town, State	
	5 Other (Specify		BAYV	IEW) CEI	METER'	Y	3	THEY	77,2008	5	LEONA	RDO, N	IJ	
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3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	injury - At home , etc. (Specify)	, farm, stre	et, factor	ry, office			28f. Location City or	n (Stree Town, S	et and Nu State)	mber or Ru	ural Route l	Number,
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam		is of examination											se(s)

DIANE AND 20a. Method of Di NX Bunal 4 ☐ Donatio 21. Signat Þ K GR 23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death) Examiner Physician/Medical IF FEMALE: 23b. Was decede in the past 1 ☐ Yes 9 Unknov Part II. Other sig Completed by 25. Was case re-examiner? Be 1 ☐ Yes 2 Certification: To 27. Manner of De Natural 2 ☐ Accident 3☐ Suicide 4 Homicide 29a. Certifier (Check only one) Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifie 2008 21438 Name and address of person no completed cause of death (Item-23a) (Type, Print) M D2140, APOLIS 441 MICHAEL

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 2

9

32 Registrar's Signature

1. Decedent's Name (First, Middle, Last) Physician 4a. Facility Name (if not institution, give street and number) /Medical Examiner Upper Chesapeake 5. Social Security Number 6. Sex 7 7. Age (In yrs. last birthday) el É **Funeral** Days Months 1□ M 2 1 F Director 30 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Funeral Director WD Abingdon 10f. Zip Code 10e. Street and Number 7-12-2008 **Yarkwa** OUTH 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 😿 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) should be filed withind Mental Hygiene. 12 Maryland 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) ို Pages 1 and 2 tment of Health 8 ric Heckrotte 3altimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) **Physician** Cuna /Medical Due to (or as a cons Examiner listate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) M Cool Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by Records, þ Completed Vital 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 XER/Outpatient 3 ☐ DOA After this

Certificate of Death 2. Date of Death 2008 22 1014 4c. County of Death 4b. City, Town, or Location of Death tartord If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) March 28, 1933 New York 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Specify: Specify: White 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Wawa Ittendant tood Market 18. Mother's Name (First, Middle, Maiden Surname) Margaret Maguth 19b. Mailing Address (Street and Number or Rural Robte Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of commetery, crematory or other place)

Evans Funeral Chapel 7-24-08 Forest Itil,

22. Name and Address of Facility

Evans Funeral Chapel + Cremation Services

3 Newport Drive Forest Hill mb 2105

Approximation, such as cardiac or respiratory arrest,

Approximatinterval Bet Onset and - MD 21015 ForestHill, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Concer to Brain 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0036487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr. Bel Bentman Steven 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bet & But

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001

4eck Ro H

Hospital or Attending

within 24 hours after death

To the Funeral Director:

filled in by

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		artment of F			iene eg. No. 200	8 24278		
	Physic /Medi		Decedent's Name (First, Middle, Last) RICHARD			HENIG		2. Date of Death		3. Time of Death		
The same of the sa	Exami		4a. Facility Name (If not institution, give str GILCHRIST HOSPICE	- /		4b. City, Town, or TOWS	Location of Death		4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security Number 220-38-9418 Usual Residence of Decedent	7. Age (in yrs. k	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/02/	1923 C2	irthplace (State or Foreign Country) ZECH REPUBLIC		
Maryland	a-f show	tor	10a. State 10b. County MD BALTIMOI		Town or Loc	cation S MILLS				10d. Inside City Limits 1 □Yes 2 🎇 No		
h with the	23a or 28a lat be noti	al Director	10e. Street and Number 15 RICHMAR ROAD,	1.	OWINGS	10f. Zip Code	21117	10	Og. Citizen of What C	JSA		
5-0036 72 hours after death with the Maryland	e. an "natural", or Items 23a or 28a-f show Modical Expraine must be notified at	d by Funeral		# E Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 2 XNo		pecify Yes or No- o Rican, etc.)		nerican Indian,		
2121 d within	r than '	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give I	ent's Usual Occupi kind of work done of OO NOT use retired MANAGE	during most of work)	ing	16b. Kind of Busines	s/Industry		
ylan vuld be	ntal ed o	To Be	17. Father's Name (First, Middle, Last) YONKEL		HEN	iIG	18. Mother's Nam	e (First, Middle, N	,	KERMAN		
_ ~	of Health and Mer item 27 is marke r other traumatic		19a. Informant's Name/Relationship (Type: JERRY STERN / NEF	*		y Address (Street a			City or Town, State	, Zip Code) 1208		
Baltimore , permit, Pages 1 a	Department of H Important: If ite any Injury or ot once,		20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	Ce	ace of Dispos meter from BETH MORIAL	sition (Name of latory or other place PARK	e) :		RANDALLS			
Dail	Depart Import any Inj once.		21. Signature of Funeral Service Licenses	lin)	22.	Name and Address	s of Facility S	OL LEVINS	SON & BROS			
	ysician Medical		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	Blacker (are	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death Wwwww.i		
	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):							
Attending Physician: The law requires that the death certificat	by the attending phy tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnan Live birth 2 Fetal of 4 Pregnant at time of de 9 Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year		
equires that	been signed should be det	ģ	Part II. Other significant conditions contrit	outing to death but not result	ting in the und	derlying cause give	n in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown		
In: The law r	cate has page 2	Completed	25. Was case referred to medical					24a. Was an autopsy perform	prior to death? death? 1 □ Ye	autopsy findings available o completion of cause of os 2 \sumbox No		
Physicia	this ald dir	To Be	examiner? 1 ☐ Yes 2 No Hosp	1 ☐ Inpatient 2 ☐ E	R/Outpatient		r: 4 Nursing Ho		nce 6/10/Other (Sp	pecify) Wispiu		
or Attending	To the Funeral Director: After completely filled in by the funeral	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) 28e. Place of Injury - At hom building, etc. (Specify)	Injury ne, farm, stree		? ′es 2 □No	28d. Describe hor 28f. Location (Str City or Town,	eet and Number or I	Rural Route Number,		
Hospital	Funeral stely filled	ledical Ce	29a. Certifier (Check only one) (Check only one)	an: To the best of my know On the basis of examination	ledge, death on and/or inve	occurred at the timestigation, in my op	l ne, date and place, pinion, death occur	and due to the ca	use(s) and manner ite and place, and di	as stated. ue to the cause(s)		
To the	To the	Me	29b. Signature and title of certifier			29c. License	number 307	29	d. Date signed (Mor	oth, Day, Year)		
	6		30. Name and address of person who complete the state of	leted cause of death (Item 2	23a) (Type, P	rint)	oi St	POWSAN	110 7	1204		
	Stat Registra		31. Cate filed (Month, Day, Year) JUL 2 9 200	leted cause of death (Item 2 Whis way (1) 32. Fingistrar's Signatu	re	all .	C3 21	,	1000	/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice Randallstown Baltimore Seasons If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months 1⊠M 2□ F 26, 1936 Maryland Director 214-30-3019 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 2108 Boston Street 21231 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces: 1 ☑Yes 2 □ No If Yes, Give Year or Dates: Korean filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No <u>م</u> Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk ment of Health and Mental H ant: If item 27 Is marked ott Be Jessie Lillian Reynolds Emil Leonard Johnson traumatic ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tra 21136 Gary E. Johnson Brother 129 Sunnydale Way Reistertown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/08 Hampstead, MD Carroll Cremation Ser 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road lon 10 ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical as the t attending IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown ģ been signed t should be deta Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ COAGULOFATHY 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has director, page 2: autopsy perform certificate 1 □ Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner SENSONI Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\mathbb{M} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: completely filled in by the 3 Suicide 6 □Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 28,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STATET REISTONSTOWN MD Charan 25 MGr Ce MAIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 9 Registrar

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it as Province Examination to the confiled at anone. Saltimore, Maryland 21215-0036

> **Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Box 68760. P.O. sate has been signed by the a page 2 should be detached to Division of Vital Records, certificate death.

For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 July 11:50PM Doris James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1458 Harwell Avenue Crofton Anne Arundel 8. Date of Birth (Month, Day, Year)
Dec. 15,1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Ane (In vrs. last hirthday) 1 □ M 2 X F Months Days Hours Min 68 219-34-0094 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 185 Virginia Avenue Apt.F U.S.A. 21061 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Book Bindery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William O. Surland Ella Kaiser 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Susan James /Daughter 1458 Harwell Avenue Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 31 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2008 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilitySingleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -0 disease or condition resulting in death) Due to (or as a consequence of): ea ses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy perform Yes 1 □Yes ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other (Specify) Residence Hospital: Other: 4 \sum Nursing Home 2 No 1∐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Certification: To 27. Manner of Leath 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as Pilal 00/5ª w di 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygienes 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AUNAPOLI If Under 1 Year | If Under 24 Hrs. 19 CIU 1050. 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 186–32–0568 **Funeral** Days Hours Min. 1**X** M 2 □ F 68 Yrs 07/09/1940 PA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "neturel", or items 23s or 28s-1 show other treumstic event, the Medical Examination ust be incitified at PA Montgomery 1 ☐ Yes 2 No Roslyn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19001 2625 Belmont Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinery Mechanic 12 permit. Pages 1 and 2 should be tife Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic avena 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lieberkneet Ado1f Kaochlin Frieda Kaechelin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marie 2625 Belmont Avenue, Roslyn, PA 19001 Kaechelin / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/31/2008 4 □ Donation 5 □ Other (Specify) Hillside Cemetery Roslyn, PA 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licensee Dorota Marshall 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Interiosclerat /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, by Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed this certificate 1 Yes 2/2/No Division of Vital : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 R/Outpatient ဥ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) ■ 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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plered ause of death (Item 23a) (Type, Print)

DUES

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOHN KIESCER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing & Rehabilitation Columbia Howard If Under 24 Hrs.
Hours Min.

8. Date of Birth (Month, Day, Year)

AUG 3, 1932 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 75 400-40-2537 **Director** Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Columbia Director Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5392 Lighthouse Court **USA** 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Social Security College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other than any Injury or other traumatic event, the I once. Personnel ManagementSpecialist Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John V. Kiesler Mary Mildred Foushee 19a. Informant's Name/Relationship (Type. Print)
Carol S. Kiesler/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5392 Lighthouse Court Columbia, MD 21044 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/28/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. Codd, 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE DEMENTIA months /Medical Due to (or as a consequence of): **Examiner** MELLITUS DIABETES Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No has certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

gupte

D0023120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAKUNMALA 9650 SANTIAGO RD GUPTA

State Registrar 31. Date filed (Month, Day, Year) JUL 2 9 2008



State

Registrar

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ERNESTINE WRIGHT, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:00 P.M. **Physician** Heinrich Walter Kerwath 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth Month, Day, Yea Feb. 18, Birthplace (State or Foreign Country)
 ND 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral ^{Year)}1922 Min Months Days Hours MD 220-05-9582 86 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai", or Items 23a or 28a-f show Exerciper to ust be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 409 Oakwood Station Road 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify: Specify: White 3 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Karl Kerwath Henrietta Stannek 2 Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Florence Kerwath /Wife 409 Oakwood Station Road Glen Burnie MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 30, Important: If it any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem.Park 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 」 | | ハート・ファント | Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) colon cancer /Medical Due to (or as a consequence of): Examiner fail renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami Seizures attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1X Inpatient ဥ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Frafter death.

I Director: After din by the funera Certification: After 5 Pending investigation 1 ☐ Yes 2 □ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital or within 24 hours af To the Funeral D 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Jane	+	Lockner					
08-05648		Please Type or Print in Black Indelible Ink. Ensure All Cop	oies Are	e Legib	le.		
JNK UNK	1-	State of Maryland / Department of Health and Mental For State Certificate of Death	Hygien		2	008 2	2428
Distriction	Re	poistrar Decedent's Name (First, Middle,Last)		Reg. N of Death	VO	3. Time of Dea	
Physician/ Medical Examine		Janet Marie Lockner	Mont July	n Da 23, 2008	3	1455 hrs	
France	48	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	eath		4c. County of D	eath	
`	L	Union Memorial Hospital Social Security Number 16 Sex 17 Age (In vrs. last birthday) If Under 1 Year If Under 24	Hrs 8 Da	te of Birth (N	N/A	. Birthplace (State	or
Funeral Director	5.	Months Days Hours M	Min.	R 9, 1	F	oreign Country) Mar	
	l	Unk 1 M 2 X F 46 Yrs.	ALI	N 99	1902		
any	_	0a. State 10b. County 10c. City, Town or Location				10d. Inside C	
iand Fshow	<u>.</u>	MD N/A Baltimore		100	Citizen of What		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meghal Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		0e. Street and Number Homeless N/A		l log.	USA	,	
ith the rith the rith the rith the rith the right of right of rich right of		1 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Y	es or No-	14. Race - A	merican Indian, Bl	ack,
r death with or items 23	<u> </u>	Armed Forces? If Yes, specify Cuban, Mexican, Put Yes 2 X No	ierto Rican,	etc.)	White, e		
s after d	اح	Widowed 4 X Divorced If Yes, Give Year 1 Yes 2X No specify:	J - 6 - - -	-0 14	Specify: Wh	nite	
hours natur Exami		15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	e retired)	ne	ob. Kind of Dasii	ess/industry	ļ
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	<u>.</u>	College (1-4 or 5+) 9 Unemployed			N/A		
5-00 ed with	5 1	17. Father's Name (First, Middle, Last)	Name (First,	Middle, Ma	iden Surname)	• 11	
21215-0036 Jude be filed within 7 IMental Hygiena Hygiene in anarked other than it event, the Medic	i l	David T. Lockner Alice	J. Li	<u>itzau</u>	er City or Town.	State, Zip Code)	
D 21 should and Mey 7 is mai	- 1	19a. Informant's Name/Relationship (Type, Print) Diane Dill/Sister 19b. Mailing Address (Street and Number 3003 Stillwater Ct I					
and 2 sho are 2 sho tealth and tem 27 is traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	1111	20c. Location - C	ity or Town, State	
nore ages 1 ant of F	- 1	Metro Crematory, Inc.	7/26/(08	Baltimo	re, MD	
Baltimore, permit. Pages I an Department of He Important: If ite Important: If ite Injury or other tr	_	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee C. Todd Dring Commetting Society	v of N	Maryl s	and, Inc		
E P P E		21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society 29 Frederick Rd 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as card	Balt	imore	MD 212	28 Approxima	ate Interval
Physician /Medical	1	failure, List only one cause on each line.	3140 01 100	atory arrow	.,	Between De	Onset and eath
caminer		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries and Drowning Due to (or as a consequence of):					. –
		Sequentially list conditions, b					
	ig	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		F			
		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - trans	edical E	d. UNPENDED AMENDED					
60, e be es ysiciar burial	힔	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	delivery	
Box 68760, a death certificate be the attending physic defor use as the bur	Physician/M	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy		Month	Day	Year
OX 6	sici	1 Yes 2 No 9 V Unknown 9 Unknown					
o. B.	튑	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.			bute to the cause o	
P.O. es that to be detace	힐		[Probably 4	
rds requi	Completed			24a. Was a autops	sy p	Vere autopsy findin nor to completion of	gs available of cause of
eco he law ate has	g l			perfor 1 🗸 Yes 2	175	eath? ✓ Yes 2	No
al R	Bec	25. Was case referred to medical examiner? Hospital: Other					
Nysici rthis o	리	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DDA 4	Nursing Ho		Residence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requin rs after death all Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending Jul 23, 2008 1400 hrs 28c. Injury at Work? 1 Yes 2 ✓ N	Sut		ped in strear		
isio Atten er deat rector i by tho	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f.	Location (S	Street and Numb	er or Rural Route N	lumber, City
Div ital or urs aftu illed in	Certification:	3 Suicide 6 Could not be determined (Specify) River/Waterfall			tate) Falls Road, B		
Hosp 24 ho Fune etely fi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	ce, and due	to the caus	e(s) and mannel and place, and o	as stated. due to the cause(s)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	and manner stated.	23002000			ed (Month, Day, Ye	
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.	OCME		July 24, 20		
		30. Name and address of person who completed bause of death (Item 23a)			<u> </u>		
2		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Ball	Itimore, N	/ID 2120	1		
St	ate	31. Date filed (Wanth, Day Year) 008 22. Registrar's Signature					

ORIGINAL

			For State	State of	f Marylan	-	artment of F		viental Hy		2000	0100
			Registrar			Cei	rtificate of I	Death			2008	
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	Day	Year	3. Time of Death
	/Medic		VIRGINIA ANN LEI 4a. Facilify Name (If not institution, g		nher)		4h City Town or	Location of Death	JULY	23 4c. Co	2008 ounty of Death	
	Examin	ier	7733 TELEGRAPH I		-		SEVERN	LOCATION OF BOATS			NE ARU	
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign intry)
	Director		218-28-6221	1 □ M 2 X F		74 Yrs.	Wolfiers Days	Hours Will.	JAN. 28			
and	MC #		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				T	10d. Inside City Limits
Mary	fied s	ţċ	MD ANNE AF	RINDEL.	SEVI	FRN						1 ☐ Yes 2 🛣 No
th the	or 282	irec	10e. Street and Number	CONDEL	DEVI		10f. Zip Code			10g. Citize	n of What Cou	intry?
death with the Maryland	23a (ral	7733 TELEGRAPH F	ED. LOT 3	32		21144			USA		
9	if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities rotal be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv	2[X No ∕e		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🏽 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Amer Black, White, becify: W.	
5-0035 72 hours aft	atural cal E		15. Decedent's	Year or Da Education	ates:	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/Ir	ndustry
	M "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1	-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worl	king			,
a Z1	ygien er th: t, the	S	8, 1			FACTO	DRY WORKE	R		COPP	ER FAC'	TORY
and d be file	and Mental Hygiene. Is marked other than aumatic event, In. M.	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	,	, Maiden Su	irname)	
aryian should be	d Mei marke	၉	EDGAR LEDNUM	(Time Drint)		105 14-10-	ng Address (Street	LOUISE (on City on T	aum Ctata 7	in Code)
≥ ਨੂੰ	ealth an m 27 Is i ner traui	1 3	19a. Informant's Name/Relationship		ATTOTTOT	1	,			ier, City or i	own, State, Z	ip Code)
s 1 a	item 2 other		MS. CRYSTAL BEAM 20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of matory or other place		Date	20c. Loca	tion - City or T	own, State
Pages	ant: If		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 Other (Spe		State		EN MEM. P.	4	LY 28 008	GLEN	BURNIE	. MD
Dali	Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lie	ensee live	M0141	22	2. Name and Addre	ss of Facility 1 2	ND AVE.	SW;	GLEN B	URNIE, MD
			23a. Parl 1. Enter the disease, or co shock, or heart failure. List on	mplications that c	aused the deat						DEIXY	Approximate Interval Between
. Ph	ysician		Immediate Cause (Final disease or condition	. ((090							Onset and Death 7 years
	Medical caminer		resulting in death)	Due to (or as a conseq	uence of):						0
		<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	or as a conseq	uonoo of\:						
/ uted	unsit	Examiner	Cause (Disease of injury	Due to	or as a conseq	derice or).						
o, A	an and rial-tra	Exa	that initiated events resulting in death) Last	C Due to (or as a conseq	uence of):						
icate be executed	physician and the burial-transit	dicai		d								
x o	ding p		IF FEMALE:	20- 16								
Othe Hospital or Attending Physician: The law requires that the death certifications are the control of the Hospital or Attending Physician:	y the attending p ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live t	come of pregna pirth 2 ☐ Feta nant at time of o own	ıl déath 3 [☐ Ectopic pregnand ☐ Other (specify)	у		23	d. Date of deli Month	very Day Year
that	ned b	by Pt	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
v requires	en sig		Coroner	y Arose	57 I),5 egs	<u>`</u>		1 🗷	Yes 2□	No 3∏ Pr	obably 4 🗌 Unknown
he law re	te has been signed by the age 2 should be detached	Completed	Congestive	- Hea	- FR	11050	sser ⁱ		24a. Was auto perf	psy ormed?	prior to death?	topsy findings available completion of cause of
a ::	n. After this certificate ha funeral director, page	0	25. Was case referred to medical	T				26. Place of Dea	1 ☐ Yes		1∟Yes	2 □No
n v	his ce I direc	70 B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ I	npatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing H	lome 5 ⊠Res	idence 6 [☐Other (Spec	cify)
i g	After t unera	on:	27. Manner of Death 1 Natural 5 Pending	,	of Injury th, Day, Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injury o	occurred	
ttend	death	icati	2 Accident investigat 3 Suicide 6 Could not	be 200 Diogo	of Injune . At h	ama form of		Yes 2 □ No	20f Logotion	/Chront and	Norman and Di	uni Dauta Numbar
o's	after Dire d Jin by	Certification:	4 ☐ Homicide determine	ed 206. Place buildi	ng, etc. (Special	fy)	reet, factory, office		City or To	wn, State)	Number or Hu	ıral Route Number,
e Hospita	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		aminer: On the b			th occurred at the tinvestigation, in my o					
To th	withir Comp	Me	29b. Signature and title of certifier	signed (Month								
	9		Muth De	ll Tur ((7)		D005	2089		7-	24-0	72
	5		30. Name and address of person who Ruth Gallatty	72401	Brun	dern	Print)	1. Suite	2206	amb	nik.	MD21051
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9	20	egistrar's Signa	ature	ack .					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death Rudolph Lyons (Eirst, Middle, Last) 2. Date of Death Day Year Month 45 PM Charles Lyons 2008 Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BAYVIEW MEDICAL CENTER BALTIMON JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 5, 1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 216-34-4685 Nov. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Baltimore txXYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 325 Pine Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 □Yes 2√√ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Trucking refl Company Elementary/Secondary (0-12) College (1-4or 5+) 11 truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Lyons Ruth Gupton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 Oak Street; Baltimore, Maryland 21222 Derrick Lyons / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 07/16/2008 Metro Crematory Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final ENCEPHALITIS WEX disease or condition

/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Aft
Completely filled in by the fur

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Medical Certification: To Be Completed by Physician/Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Maddall Evan, man is used to notified a

Physician

and physician a

attending p

been signed by the should be detached

cate has to page 2 s certificate

this After thi funeral

2 SOLPH

Saltimore, Maryland 21215-0036

resulting in dealin)	Due to (or as a consequence of):	(
Sequentially list conditions, and any, reading to immediate cause. Enter Underlying	b. CLYPTOCOCLAL MENING, 1715 Due to (or as a consequence of):	YELANS							
cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	c. LIVEN FAILURE Due to (or as a consequence of):								
soung in abduly 2450	d. CIDNEY FAIW 2E	YELARS							
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
ert II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.	o the cause of death? Probably 4 ☐ Unknown							
	autopsy prior to	utopsy findings available completion of cause of s 2 140							
. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
7. Manner of Death 1 → Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fig. City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and inner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and duand manner stated.								
9b. Signature and title of certifier	29c. License number 29d. Date signed (Mon	th, Day, Year)							
· Quiton)	Mes-000 July 13, 2	2008 altimore,MDev							
0. Name and address of pars who	completed cause of death (Item 23a) (Type, Print)	1 M.X							
Christopher	BRADY MD 4940 Eastern Avenue Be	altimore. MDzi							

Registrar

State

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State Cortificate of Death										24200	
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of D							
	Physici		DIANA R	LEN'	TZ				JULY	27 2	8°OO	7:31 PM	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	^		4b. City Town	r kocation of De		4c. Count	y of Death		
			Mercy fledical Center				Baltinore			N/A			
	Funeral		Social Security Number 6. Security Number		(In yrs. las	-	If Under 1 Year Months Days	If Under 24 H		h y, Ye <i>ar)</i>	9. Birth	place (State or Foreign ntry)	
	Director			□M 2□F	66	Yrs.				1941	Mar	yland	
	and w	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation					10d. Inside City Limits	
	be filed within 72 hours after death with the Maryland ald Hygiene. Ald Hygiene. Other than "natural", or teme 23a or 28a-f show other than "natural" or teme 23a on 28a-f show ovent. It a Medical Examinar must be notified at		MD N/A		Bal	timo	ce				-	1 ∑ Yes 2 □ No	
		Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
			726 S. Durham Street			21231				U.S.A.			
		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No		ce - Ameri ack, White,		
36	or It	þ	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 ☐ N If Yes, Give	lo		1 ☐ Yes 2 ☑ No	Specify:	,		ity: Wh		
21215-0036	urel',		3 Widowed 4 Divorced	Year or Dates:	1		dent's Usual Occup	entine		16b. Kind of			
15	in 72	olete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of work done DO NOT use retire	during most of w	vorking	100. Kind of	Dualiteaarii	idusiiy	
212	y with	Completed	Elementary/Secondary (0·12)	College (1-4or 5	+)		Homemake	r		Own	Home		
	al Hygie other	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle	Maiden Suma	ame)		
/lar	should be find Mental Is marked of	To B	Owen Doxsey					Mary	T. Okel				
Maryland	335		19a. Informant's Name/Relationship (7	ype, Print)			3		Rural Route Numb				
2	and lealth m 27		Mr. Irvin Lentz/	Husband	20h Dia		sition (Name of	Street	Baltimor	20c. Location			
Baltimore,	H lte		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cem	etery, crer	natory or other pla						
草	t. Pa ntmen rtant: njury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen		Park		Cemetery		31/2008			Maryland dalk, Inc.	
Ba	permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is eny injury or other treu once.		21. Signature of Purishar Service Licent			- 24			e Dundall				
	e		23a. Part 1. Enter the disease, or comp	lications that caused	the death.	Do not ent						Approximate	
	Physician		shock, or heart failure. List only one cause on each line. Interval between one of the cause on each line. Onset and Death										
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Mustastark fundl Cell Ung Cauxer Due to (or as a consequence of):									19	
R.	Examiner												
7	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying										
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8760,	ate be executed hysicien and the burial-transit												
687	tificate og phys as the	edicai		d									
Вох	death certific e attending p od for use as	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			3			23d. Date of de		very	
	0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ ¥o	4 Pregnant at	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				'	Month Day Year			
P.O	that the de led by the a detached	Physician/Me	9 Unknown	9□ Unknown									
s,	es De	þ	Part II. Other significant conditions of	ontributing to death bi	uting to death but not resulting in the underlying cause given in Part I.				cco use contribute to the cause of death?				
ord	w requir been si should	ted						_	Yes 2 No 3 Probably 4 Unknown				
Vital Record	e law has b	Completed							24a. Was	an 241 psy ormed?	b. Were aut prior to c death?	opsy findings available ompletion of cause of	
									1 Yes	2 No		2 No	
Zit	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: 1 Impatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?									
	F F F	1: To	1 Yes 2 No 27. Manner of Death								ary)		
ion	nding Ph uth. r: After th e funeral	ation	1 Natural 5 Pending 2 Accident investigatio										
Division	or Attending after death. Director: After in by the fune	titica	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At nome, farm, street, factory, office 201. Locat						cation (Street and Number or Rural Route Number, by or Town, State)			
Ö	tel or A	edical Certification:		Supplies (appears)									
	To the Hospitel or Attentwithin 24 hours after deatl to the Funeral Director: completely filled in by the		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the Within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)									12				
S J.NAZARIANIMO 201 ST. Paul ST talking MD 21202										14			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balmmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 212-09-5130 7. Age (In yrs. last birthday) 91 yrs. **Funeral** Days Min. Months Hours 1 □ M 25€ F Apr 19, 1917 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore City Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21224 701 South Potomac Street Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American : 1 and 2 should be filed within ' Health and Mental Hygiene. tem 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Can Company 9th Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) John Czawlytko Henrietta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 701 S. Potomac St. Baltimore, Md. 21224 Kenneth Lukaszewski /son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H
Important: If Ite
any injury or of
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) StanislausCem7-30-2008 Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licens) e Tabel 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic cancer, unlenaun Week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation after death.

| Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide or To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar

31. Date filed (Month, Day, JUL 29



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29c. License number

UMP 19027

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APPLO THE WEST OF THE WAST. THE WORLD THE WAST. T Reg. No. 2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ller 9:02 FM Marquerte 2008 TUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🛣 F 63 Director 217-42-1439 OCT 5, 1944 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b County 10c. City. Town or Location show notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Crofton 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 23a or 1812 Lang Dr 21114 USA must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Unk ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Medicine Nurse Practitioner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite K. Summers William Wilson Miller ဂ္ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5528 Tallow St Fredericksburg, VA 22407 Timothy Miller/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/28/07 20c. Location - City or Town, State Department of important; If It any Injury or o once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, Inc 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Todd Dring 299 Frederick Rd Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS 5 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ABSCESS LIVER wecks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) d by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 2 🗆 No 1 TYes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) nours after death.

neral Director: After this or y filled in by the funeral dire 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation Attending 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined ō Hospital 24 hours 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hou To the Funel completely fi (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 08 MD 0 30. Name and address of person who oppleted cause of death (Item 23a) (Type, Print) AGGARNAL 600 North Wolfe St, Baltimore, MD, 21287 NISHA MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ricky Lynn Mullins July 2008 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1024 Ward Street Prince George's Laurel 8. Date of Birth (Month, Day, Year) Jan. 25, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 T F Director 413-02-6940 Tennessee 48 1960 Usual Residence of Decedent 10a State 10b. County s 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No Prince George's Laurel filed within 72 hours after death with the I Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1024 Ward Street 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or items other traumatic event, its Medical Examination 11. Marital Status 14. Race - American Indian, Black White etc 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofer Orndorff & Spaid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be file of Health and Mental H fitem 27 Is marked oth Be Phil Roberts ပ Lennie Pearl Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Mullins/Wife 1024 Ward Street, Laurel, MD 20707 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 7/25/2008 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 anucl 313 Talbott Avenue, Laurel, MD 23a. Part 1. 5 fer tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) advanced hepatocellule cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last nei Due to (or as a consequence of) Exami signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of) death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 ☐ Unknown alcoholabuse 1 ∏Yes 2 ∏No 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an performed? Yes 2 No 1 🗆 Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10. Name and Address of person who completed cause of death (Item 25 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

2008

32. registrar's Signature

29c. License number

D53070

29d. Date signed (Month, Day, Year)

July 24, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			1 - State Registrar		State of Ma	arylani			te of L		ITIG IVI		Reg. No	/ 111	8	2429	2
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	/Medic	al		e Richard If not institution, give				4b Cib	/ Town, or	Location o	f Death	July	40	26 County o	2008 of Death	5:15 p	
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	Funeral		5. Social Security N	lumber 6. Sex		e (In yrs. I	ast birthday)	If Und	or 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year	,	9. Birthpl Coun	ace (State or Foreigny)	gn
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980	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exator at must be coulled at once.	Completed by Funeral		ied 2 Married	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:		1		ecify Cubai		, Puerto	cify Yes or N Rican, etc.)		Specify:	c, White, o	nite	
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o uo	ding P. h. After ti funera	tlon:	27. Manner of Dea 1 XNatural	th 5 Pending investigation	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	of M	28c. Injun Wor	yat k? Yes 2 □		28d. Describe	e how inj	ury occuri	red		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inbuilding, e	ijury - At ha tc. <i>(Specif</i>	ome, farm, st						(Street a		er or Run	al Route Number.	
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Funeral Director		212-31-3413	Sex 7. Age	(In yrs. last	birthday) If Undo Month	er 1 Year If Under s Days Hours	Min	Date of Birth(Foreign		MD
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show an other traumatic event, the Medical Examiner must be notified at once.	Director	1289 Limit Av	enue			1239			US	A		
vith th		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decede	ent of Hispanic Orig	in? (Specify	/ Yes or No-		ace - Americ	an Indian	, Black,
eath v	Funeral	1 Never Married 2 Marrie	Armed Forces?	X No	If Yes, speci	fy Cuban, Mexican,	Puerto Rica	in, etc.)		hite, etc.	1-	
after c	by F		ed If Yes, Give Year or Dates:			X No specify:		lana I		y: Bla		
hours	ed t	15. Decedent's Education (Specify		,	6a. Decedent's Usual during most of wo	Occupation (Give I rking life, DO NOT	use retired)	done	bb. Kind of	Dusiness/ii	lidustry	
36 in 72 than "	pet	Elementary/Secondary (0-12)	College (1-4 or 5	· 1	ink			l,	ink			
d with	Completed	12th grade 17. Father's Name (First, Middle, La	N/	<u>A I</u>	NI (IC	18.Mother	's Name (Fir	st, Middle, Ma	iden Surna	me)		
21215-0036 uld be filed within 7 Mental Fygiene. marked other than e event, the Medica	Be (Purnell C. M				Bark	para	Ann <u>T</u>	aylo	r		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examiner must	٩	19a. Informant's Name/Relationship			19b. Mailing Addres							
ME and 2 si alth ar alth ar raunia		Purnell C. M 20a. Method of Disposition	osby-rath		ace of Disposition (Na	efton Av		Balt	20c. Locati	on - City or	Town, Sta	z <u>z 4</u>
Ore, es 1 a of He If ite		1 Burial 2 X Cremation	3 Removal from Sta		ematory or other place		7-29	3-08	Bal	timor	ce, i	MD
Baltimore, MD oemit. Pages I and 2 shc operatment of Health and important: If item 27 is injury or other traumati	-	4 Donation 5 Other Spec 21. Signature of Funeral Service Lice		Ш.,		d Address of Facility			/II D		_	
Balti permit. Departm Importa		21, Signature of Fulleral Service Lic	2 47 04	1290	\	Ol E. No	Ma	rch F			. M:	21202
Physician	-	23a. Part I. Enter the disease, or co	mplications that caused	the death. [Do not enter the mode	of dying, such as c	ardiac or res	spiratory arres	st, shock, or	r heart	Approx	imate Interval en Onset and
Medical	1	failure. List only one cause on Immediate Cause (Final disease	a. Multiple Sharp I	orce Inju	uries							Death
(caminer		or condition resulting in death)	Due to (or as a cons	equence of)								
	ī	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of)	:							
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE:	23c. If yes, outco	me of pregn	ancy				23d. Da	te of delive	ry	
Box 68760, a death certificate be the attending physic of for use as the bur	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of dea	2 Fetal deat		ic pregnancy	4	Mon	th	Day	Year
OX (eath or attenue for us	/sici	1 Yes 2 No 9 Unkno	7	time of dea	other (Sp	ecify)						
D. B t the d by the		Part II. Other significant condition		h but not re	sulting in the underlying	ng cause given in P	art I.					e of death?
P.O.	d by											Unknown
rds requi been	lete							24a. Was a autop:	sy	prior to	completio	dings available on of cause of
eco he law ite has	Completed					· · · · · · · · · · · · · · · · · · ·		perfor 1 Yes		death?		2 No
al R an: T ertifice stor, pa	BeC	25. Was case referred to medical				26.Place of Death						
Vita hysicia this co I direc	0	examiner? 1 ✓ Yes 2 No			ER/Outpatient 3	DOA Other	Nursing I	Home 5		6 Oth	er: Scene	
On Of ending Pl ath or: After he funera	tion: T	27. Manner of Death 1 Natural 5 Pendir		Year)	28b. Time of Injury FOUND: 2230 hrs	28c. Injury at Wor	No SI	ubject sus	tained sh	narp forc		
Division of Vital Records, rat or Attending Physician: The law requir rafter of the Therman The The The The The The The This certificate has been side in by the funeral director, page 2 should the The This certificate has been side of the This certificate has	rtifica	2 Accident Investi 3 Suicide 6 Could determ	not be 28e. Place of I	njury - At ho	ome, farm, street, factors e / Rowhouse	ory, office building,	etc. 28	8f. Location (\$ or Town, S 289 Limit Av	Street and Natate) e., Baltimo	Number or F ore, MD	Rural Rout	e Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical Certification:	29a. Certifier 1 Certifying Phy	rsician: To the best of r iner:On the basis of ex	ny knowledo	ne death occurred at t	the time, date and p my opinion, death o	place, and de occurred at t	ue to the caus he time, date	e(s) and mand place,	anner as st and due to	ated. the cause	(s)
To the To the comp	Med	29b. Signature and title of certifier	and manner stated			29c. License numbe	er			e signed (M		
		100, 11	, 1/2 ,			O.C.M.E.	00	CME	July 21	1, 2008		
1		3. Name and address of person v Theodore M. King, Jr.,				Penn Street, B	altimore.	MD 2120	1			
9	tate		32. Registr	ar's Signatu	ys /							
Regis		1111 0 0	2008 Alexander	المحر المناكم	1 foods							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** July 26 John Gilmour McAfee 7:30 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Hours 1 → M 2 □ F Director 215-34-5044 82 June 11. 1926 Canada Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3203 Winnett Road 20815 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Radiologist Medical 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H important: If Item 27 is marked oth any Injury or other traumattc eveni Be of Health and Mental I Item 27 is marked of Robert Duncan McAfee ပ Susan Damery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul C. McAfee, MD 521 Belfast Road; Sparks, MD 21152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/28/08 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Syrvice icense 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part 1. Enter me disease, or complication that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence off Exami attending physician and Due to (or as a consequence of) Box 68760. The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 2300 DULANEY VALLEY ROAD

21093

MD

TIMONIUM,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

ERNESTINE WRIGHT,

31. Date filed (Month, Day, Year)

2008	24	2	9	
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Tyrone Je	ssi	e Me Cray						
08-05741		Please Type or Print in Bla					jible.	
UNK UNK		State of Maryland /	•	ent of Health a ate of Death	and Menta		200	8 2429
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Oer uno	ale of Dealif		C Date of Death	g. No.	3. Time of Death
Medical Examir		Tyrone J. McGray Jr.				Month July 26, 20	bay July 27,20	18 0253 hrs
1		4a. Facility Name (if not institution, give street and number)		_ *	, or Location of D	eath	4c. County of Death	
E	4	Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age ((In yrs. last bir	Baltimore		/Um 8 Date of Birth		hplace (State or
Funeral Director		212-94-6749 1X M 2 F	28	Months [Days Hours	Min	Foreig	
-	H	Usual Residence of Decedent		Yrs.		10-12	1979	, [·[D
v any		10a. State 10b. County 11	0c. City, Town	or Location				10d. Inside City Limits
fand f shov	ē	MD Baltimore	Randa]	llstown	_			1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 8801 Falcon Ridge Drive		10f. Zip Cod	l1.33	10	g. Citizen of What Cour USA	itry?
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death v	Funeral	1 Never Married 2 Married Armed Forces?	No	If Yes, specify Cu			White, etc.	
after aft.	by	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:		1 Yes 2 X				can-American
hours "natu	ted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+		Decedent's Usual Occi during most of working			16b. Kind of Business/I	ndustry
036 thin 7; than edical	Completed	11th		siness Manager	c		Tyrone's Chic	cken
5-0 lled wi Hygier I other		17. Father's Name (First, Middle, Last)				Name (First, Middle, M		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Tyrone McCray Sr. 19a. Informant's Name/Relationship (Type, Print)	T 10	h Mailing Address /S		icia Marie I	ABORG ber, City or Town, State	7in Code)
	F	Patricia Outchember/ Mother		3801 Falcon Ri				, Zip Code)
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumant	Ī	20a. Method of Disposition		of Disposition (Name of tory or other place)	f cemetery,	Date	20c. Location - City or	Town, State
MOI Pages Tent of	-	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify:		Amorial Park		8-1-08	Woodlawn, MD	
Salti ermit. epartn nports	Ì	21. Signature of Funeral Service Licensee	11.					Baltimore Co.
	J	23a. Part I. Enter the disease, or complications that caused the	ICC Do n		,	andallstown,		Approximate Interval
Physician /Medical	1	failure. List only one cause on each line.		ot enter the mode or dy	ing, soon as care	nac or respiratory arre	SSI, SHOOK, OF HEAR	Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Due to (or as a conseq						
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760, cate be physic he bur	Med	IF FEMALE: 23c. If yes, outcome			,WO		23d. Date of deliver	<u> </u>
Box 68760 c death certificate b the attending physi	ian	3b. Was decedent pregnant in the past 12 months?	6 -1	2 Fetal death 5 Other (Specify)	3 Ectopic p	regnancy	Month I	Day Year
Box death the atte	ysi	1 Yes 2 No 9 Unknown g Unknown		5 Other (Specify)	-			
ords, P.O. Box 68760, wrequires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial - tran	by P	Part II. Other significant conditions contributing to death t	out not resultir	ng in the underlying cau	ise given in Part		bacco use contribute to	
duires	ted	• • • • • • • • • • • • • • • • • • • •				24a. Was	an 24h Were a	utopsy findings available
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/ital	o Be	examiner?	2 V ER/C		Othor		Residence 6 Othe	r:
of \ng Phy		27. Manner of Death 28a. Date of Injury	28b.		Injury at Work?		how injury occurred	
ion trendi death. the fi	atio	1 Natural 5 Pending FOUND: Day, Year Pound 2 Accident Investigation Jul 26, 2008		UND: 1[60 hrs	Yes 2 🗸 N	Subject sho		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Inju		farm, street, factory, offi	ce building, etc.	or Town, S	Street and Number or Ri	
Division Biospital or Attendi 24 hours after death. Funeral Director: stely filled in by the f		4 W Homicide			e date and place		Ivanhoe Avenue, Ba	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.	Medical	one) 2 Medical Examiner: On the basis of exami						
F 97	B	and manner stated.	20	29c. Lic	cense number		29d. Date signed (Mo	onth, Day, Year)
		Tark Jeg 6	WD	0	.C.M.E.		July 27, 2008	
27	ļ	30. Name and address of person who completed cause of dea Tasha Greenberg MD. Assistant Medical			et Baltimero	MD 21201		
Sta	ate	-				, IVID 21201		
Registr	rar	31. Date filed (Month, Day, Year) 9 2008 32. Registrar's	w M	Bracket				

08-05295 Robert T. Nelson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24296

		- For State Certificate of L	Death		Reg	. No.	
Physician Medical Examine	1	. Decedent's Name (First, Middle,Last)		:	2. Date of Death Month	Day Year	3. Time of Death 1054 hrs
Wedical Examine		Robert T. Nelson la. Facility Name (if not institution, give street and number) 4b.	. City. Town, or	Location of Death	July 10, 200	4c. County of Deat	
			Clinton			Prince Georg	e's
Funeral	;	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Day		8. Date of Birth	(MM/DD/YYYY) 9. Bii Forei	an I
Director	L	400-56-8967 1XM 2 F 68 Yrs.	Months	s Hours Will.	MAY 22	1940 C	ountry) KY
any	-	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
€		MD Prince Georges Clinton					1 Yes 2 X No
the Maryland or 28a-f show iffed at once.	ᇙ	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Cou	ıntry?
th the Maryland 23a or 28a-f sho notified at once.		5813 Garden Drive	20735			USA	
r death with or items 23	2	1 Never Married 2 Married Armed Forces?		spanic Origin? (Spe n, Mexican, Puerto I		14. Race - Ame White, etc.	rican Indian, Black,
fter de		Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year 1 Yes	res 2 X No	specify:		Specify: Bla	ack
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1215 be file mtal H rirked	a	unk Nelson		Cardenia		Boone	
MD 21215-0036 12 should be filed within 7 127 is marked other than matic event, the Medica	2[per, City or Town, State	
and 2 and 2 Tealth item 2 traum	-	20a. Method of Disposition 20b. Place of Dispositi	ion (Name of ce		Date	20c. Location - City of	
nore ages 1 ant of F at: If i		1 Burial 2 X Cremation 3 Removal from State crematory or othe 4 Donation 5 Other Specify: Metro Crem		Inc 7/25	5/2008	Baltimore	a MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 sho injury or other traumed at the Medical Examiner must be notified at once.						land, Inc.	
	Ш	29	9 Frede	rick Road	l, Balti	more, MD	21228 Approximate Interval
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kaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardio Due to (or as a consequence of):	vascular Di	sease			
		Sequentially list conditions, b					
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
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Box 68's death certification attending	clan	past 12 months? 4 Pregnant at time of death 5 Other	al death 3 er (Specify)	Ectopic pregna	ncy	Month	Day Year
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w requires the very requires the seen signs should be defined by) Ted	anonic decreasin			24a. Was a		autopsy findings available
e law r e has b	Completed	-			autops perfor	med? death'	
ital Recician: The scertificate rector, page	3	25. Was case referred to medical	26.Plac	ce of Death (Check	البيتا	INO I V	165 Z NO
Vita hysicia I direct		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA	Other Nursin	g Home 5		ner:
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isior Attend ar death, rector: by the i	Cati	2 Accident Investigation 280 Place of Injury. At home farm street			28f. Location (S	street and Number or	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Directly filled in t	Certification:	3 Suicide 6 Could not be determined (Specify)	,, 1001017, 011100	5	or Town, S		
롱조립원 2	edical c	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	ed at the time,	date and place, and	due to the caus	e(s) and manner as si	tated.
To the within 2 To the complet	Med	 one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier 		nse number		29d. Date signed (A	
		That IN V.	0.0	.M.E. OCI	ME	July 11, 2008	
Λ.	+	30. Name and address of person who completed gause of death (Item 23a)					
4		g,,	111 Penn S	treet, Baltimor	e, MD 21201		
Stat Registra	te	31. Date filed (Montp. Day, Year) JUL 2 9 2008 32. Begistrar's Signature	100				

			1 - For State Registrar	State of Ma	aryland / I	Depa <i>Cer</i>	rtment of Hetificate of L	ealth and N Death	/lental Hy	giener	2008	24298
	Physici	an	1. Decedent's Name (First, Middl	e, Last)				-	2. Date of De	eath Day	Year	
,	/Medic	al	Murugesan 4a. Facility Name (If not institution	and attent and a wheel	Natara	jan	th City Town or	Location of Doub	200	4 2	7 2 cc	
	Examir	er	Jewish Convale	,			4b. City, Town, or Pikesv:				altimo	
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. B	rthplace (State or Foreign country)
	Director		n/a Usual Residence of Decedent	TAM ZUF	63	Yrs.			May 12	, 194	5 I	ndia
	yland how		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	8a-1	Director	Tamilnado	n/a	Che	nnai	1					1 ☐ Yes ¾QXNo
	with the		10e. Street and Number #8 Peter Stree	t			10f. Zip Code 600 049				en of What C dia	country?
	death	Funeral	11. Marital Status	12 Was Decedes 5	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No		4. Race - Aл	erican Indian,
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then *natural', or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No	1	Yes, specify Cubar	Specity:) Rican, etc.)		Black, Wh	
5	72 hc natur	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a	. Deced	ent's Usual Occupa kind of work done d OO NOT use retired;	ation Juring most of work	king	16b. Kir	d of Busines	s/Industry
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	e filed al Hygie other vent,	Be C	17. Father's Name (First, Middle,		I	11	anager	18. Mother's Nam	ne (First, Middle	, Maiden		
ylar	should be ind Mental marked o	To E	Natarajan Muda		-			Thiridur				
Maryland	12 sh th and 7 ie m treum	(8)	19a. Informant's Name/Relations Vijayakumar				g Address (Street a			•		
	f Heel fram 2 other		20a. Method of Disposition		20b. Place of	of Dispos	liver Hei		Owings Date			ZIII Z r Town, State
altimore,	Page nent o ant: if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State ipecify)		•	remation,		3-2008	Hamp	stead,	MD
Balt	permit. Pages 1 end 2 should by Deperment of Heelth and Menta important: if Itam 27 ie marked eny injury or other treumatic espice.		21. Signature of Fun Service	Licanson			. Name and Addres ine Funer	-	11824 F			
ı		_	23a. Part1. Enter the bisease, of shock, or heart value.	complications that caused only one cause on each lir	the death. Do						-,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition									Oncest and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	culer				, ,	7 bmarlly
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S	ocuted ind transit	Examiner	Exquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.								
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687		edical		d						1		
Box	leath certifi ettending I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		n 3□	Ectopic pregnancy			2	3d. Date of d	•
P.O. E	at the dea by the et reched fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death		Other (specify)				Month	Day Year
	that the	by Ph	Part II. Dther significant condition	ons contributing to death bu	ut not resulting i	in the un	nderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
rds	w requires that been signed b should be deta	ed b							10	Yes 2[□No 3□	Probably 4 Minknown
Division of Vital Records,	sician: The law requires that the death certificate has been signed by the ettending irector, page 2 should be deteched for use a	Completed				-			24a. Was auto perf 1 Yes	s an opsy ormed? 2 M No	death'	autopsy findings available completion of cause of
/ital	clan: ertifice ector, p	Bec	25. Was case referred to medica examiner?					26. Place of Dea		_		
 	Physi this c	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		utpatien		4 Tyursing H	ome 5 Res			pecify)
o	th. : After I	tlon	1 Matural 5 ☐ Pendir Z ☐ Accident investi	ig (Month, Day		Injury	Work	Yes 2 □ No	Zau. Describe	now injury	Cocumed	
Divis	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place of Inju- building, etc		arm, stre	eet, factory, office		28f. Location City or To	(Street and	d Number or	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta								
	To th To th compl	Me	29b. Signature and title of certifie		^		29c. License	number		29d. Dat	e signed (Mo	nth, Day, Year)
•			• Jew	Van V	~>		1941	1817	-	Ju	ly o	182008.
	2		30. Name and address of person	Physical cause of de	eath (Item 23a)	(Type,	34 L/2c	luile	re a	ne	Bel	hillore
	Sta Registr		31. Date filed (Month, Day, Year)	008 32. Registra	ar's Sinnature	bere	re la la la la la la la la la la la la la	_				nth, Day, Year) 28 2008.

Noterejan Hym gesan.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 24299 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1355 hrs : Examiner Judy Nicks July 18, 2008 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7849 Somerset Court Greenbelt Prince George's 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number **Funeral** 532-74-4814 07/30/1959 Months Day Director 48 M 2X F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location MD Prince George's **Greenbelt** 1 X Yes 2 No 28a-f show s 23a or 28a-f show notified at once. hours after death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7849 Somerset Court 20770 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 X No Yes 9 **Black** Widowed Divorced Give Yee Yes 2 X No specify: tt: If item 27 is marked other than "natural", other traumatic event, the Medic A Examiner ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ within 72 timore, MD 21215-0036.

E. Pages I and 2 should be filed within 7. Iment of Health and Mental Hygiene. LAW 12 5+ Attorney 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Ear1 Nicks Ross Evelyn traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Willie Earl Nicks / Father 805 Woburn Abbey Road, Glen Dale, MD 20769 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date timore. crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State Important: injury or oth Montevallo Cemetery 7/26/2008 Montevallo, AL Donation 5 Other Specify 9 permit. Departm 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dorota Marshall Charles L. Stevens 1501 Fast Fort Ave Funeral Avenue, Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval าysician Between Onset and failure. List only one cause on each line Medical Death a Intracranial Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED e attending physician for use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown ned by the a detached for signed by the detacher 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş Yes 2 No 3 Probably 4 ✔ Unknown Completed been 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? certificate ✓ Yes 2 No 1 V Yes Hospital or Attending Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Hospital: 1 Other-DOA Nursing Home 5 Residence 6 V Other: Scene Innatient 2 ER/Outpatient 3 this 1 Yes 2 28a. Date of Injury (Month, Dey,Yeer 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 V Natural Pending Yes 2 No To the Funeral Director: completely filled in by the Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 19, 2008 O.C.M.E.

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

Pamela E. Southall, MD

9

31. Date filed (Month, Day, Year)

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 27 Day 2008 Year Fernando Najera 1:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Baltimore Towson 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 36 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-15-1972 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min California 571-73-7936 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Evanther must be notified at MD Baltimore Director Lutherville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 Kellogg 21093 U.S.A. Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Ruerto Bican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ene. than "natural", or i Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: Mexican þ Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Sheriff Law Enforcement marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Fernando Najera Elvia Hernandez Aguilar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Lynn Najera / Spouse 814 Kellogg Rd., Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest
Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07-31-2008 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Ad ress of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 10 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops, performer page certificate 2 No 1 ☐ Yes 1 Yes : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending death. 124 hours after death.

Funeral Director: # investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2. 29b. Signature, and title of certifier 29c. License number 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

rauknes

31. Date filed (Month, Day, Year) JUL 2

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P^{M} Milton Van Evera 0aklev 26, Julv 2008 1:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 1-1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min 306-16-6239 90 JAN 28, 1918 Minnesota Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd, Apt 4528 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1941–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant.! If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exeminar mant be notified at ury or other traumatic event, the Medical Exeminar mant be notified at Baltimore, Maryland 21215-0036 Department of Important: If it any Injury or concept on the source of th

Physician

/Medical

Examiner

10a State

Director

Funeral

Director

Physician /Medical **Examiner**

law requires that the death certificate be executed the burial-tran physician as use for detached cate has been signed by page 2 should be detach certificate has or Attending Physician: The funeral director, After this

P.0.

Division of Vital Records,

19a. Informant's Name/Relationship (Type. Print) Rhoda M. Oakley/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but got resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy perform 1 ∐Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) . Manner of Math 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Funeral Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Paper Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter D.Oakley ဥ Catherine Van Evera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Wlather Blvd, Apt 4528 Parkville, MD 21234 20c. Location - City or Town, State Metro Crematory, Inc. 7/28/08 Baltimore
Oring Cremation Society of Maryland, Inc.
299 Frederick Rd Baltimore, MD 21228 Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ofiset and Death aci re Vascular disease 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably → Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date, signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: A

To the Hospital

filled in by the

completely

550 W. Towsento

32. Registrar's Signature

Physiciar /Medica Examine
uneral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23 or 28a-f show enjoying or other traumatic event, Ita Madical Examination to a confined at the

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

-	For State Registrar		tificate of Deat		Reg. No		
ian	Decedent's Name (First, Middle, Last)	l- (16		e of Death		3. Time of Death
cal	4a. Facility Name (If not institution, give street and number)	1 1.	4b. City, Town, or Location	on of Death	ly 24	County of Death) . 4 0 M
ner	St-T-lizabeth Nursing	Center	Bal	Fimure		N/A	
	216-03-3728 1 1 M 2 T F 9	n yrs. last birthday) 4 Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. Date 's Min. (Mo Oct	e of Birth nth, Day, Year, L. 1, 1	913 9. Birthp Cour Man	place (State or Foreign cyland
		Oc. City, Town or Lo				1	Od. Inside City Limits
ctor	MD Baltimore		Arbutus	S 			1 □ Yes ※ No
ai Dire	10e. Street and Number 5538 Willys Avenue			L227		tizen of What Cour United S	
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates:		Nas Decedent of Hispanic f Yes, specify Cuban, Mexi 1 ☐ Yes 2 X No Spec		es or No- etc.)	14. Race - Americ Black, White, Specify:	
npieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during n DO NOT use retired)	nost of working	16b. i	Kind of Business/In	dustry
Con	6 17. Father's Name (First, Middle, Last)		Homemaker	other's Name (First,	Middle, Maide		wn Home
To Be	Adam Malinowski			Laura Sw	incnska		
	19a. Informant's Name/Relationship (Type, Print) E. B. Okonski - Son		ng Address (Street and Nur 2 Harborwood				
	20a. Method of Disposition	20b. lace of Dispo	esition (Name of	Date		Location - City or T	
	1 Sturial 2 ☐ Cremation 3 ☐ Removal from State	Morrorial	natory or other place) Ldge Lark	7-29-200		kridge, 1	
	21. algnature or Funeral Service Libertsee		2. Name and Address of Fa 328 Sulphur S				
		e death. Do not ent	er the mode of dying, such	as cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):					
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delin Month	very Day Year
by	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in P	art I. 23	3e. Did tobacco	o use contribute to	the cause of death?
Completed		/ascula	r Accide		4a. Was an autopsy performed? ☐ Yes 2001	prior to c death?	topsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner?		/ Others N	Place of Death Che			
မ	1 Yes 2 (No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day)	28b. Time o			i □ Residence rescribe how in		sify)
ertifica	a Could not be	r - At home, farm, st (Specify)	reet, factory, office		ocation (Street ity or Town, St	and Number or Ru ate)	ral Route Number,
Medical Certification:	29a. Certifier (Chack only one) Certifying Physician: To the best of examiner: On the basis of examiner state	xamination and/or in	th occurred at the time, dat nvestigation, in my opinion,	te and place, and du death occurred at t	ue to the cause the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier	Suns	29c. License numl	3 9 1	29d. (Date signed (Monti	\sim
te	30. Name and address of person who completed cause of deal of the state of the stat	ion Ave	nue, ba	Himon	e, M	aryland	, 2008°

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24303 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Eileen Jean Peterson 0804AM /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince George's Doctors Community Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 23,1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗓 F Min Days Hours New York 546-50-8415 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Directo Maryland Prince George's 1XYes 2 □ No Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Crescent Road Apt B. 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 P A 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald E. Lester Josephine Cristantiello ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Peterson, Daughter 9 Maplewood Court Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07/24/08 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Utensee 22. Name and Address of Facility. Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to (or es a consequence of): Examiner consequence of): Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed s certificate has be irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □Yo 24a. Was an autopsy performe 1 ∐Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient After this 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day, Year) Certification: 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 67/21/08 MDD61131

State Registrar 3118 Good Luck Rd, Lanham, MD. 20706

nd address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2008 24304

			1 - State Registrar		(Certi	ficate of I	Death		Reg. No.		2 100	
		×	1. Decedent's Name (First, Middle, L	.ast)					2. Date of De Month		v Year	3. Time of Death	
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	Funeral Director		5. Social Security Number 6. 578-80-5216	Sex 7. Age	(In yrs. last birth 58		If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Mar 13	ay, Year)	Co	hplace (State or Foreign untry) lippines	
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	trylar show d at	_	10a. State 10b. County		10c. City, Town	or Locat	tion					10d. Inside City Limits 1 ☐ Yes 2 🛛 No	
	e Ma Ba-f s	응	MD Prince	George	Laurel								_
	be filed within 72 hours after death with the Maryland Hygiene. 4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10e. Street and Number 8703 Locust Grov	io Drivo			10f. Zip Code 20707			10g. Citi	izen of What Co	untry?	
	ns 23 mus	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Wa		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		14. Race - Ame		-
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	ling P	ii ii	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		me of jury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe	how inju	ry occurred		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 24307 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John P. Roberts, Jr. 11:15 a July 26, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Westminster Carroll 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 1 M 2 □ F **Director** 213-28-8078 15,1931 76 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Vedical Exantinal must be notified at Director 1 ☐ Yes 2 ☑ No Hampstead Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 1922 Hanover Pike 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ Specify: 3 Widowed 4 N Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Computer Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John P. Roberts, Sr. 2 Alma Buie Cornell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 trment of Health? item 27 John P. Roberts, III 127 Hammershire Road Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 7/28/08 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** NETHON, disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to hinne flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 7 - 28 - 0829b. Signature and title of certifier 29c. License number Banszyla WD D51705 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 DR. Westminstoz, MD 21157. AMSURIA 349 Mal 31. Date filed (Month, Day, Year) State Registrar

Donell Rogers 08-05701

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 24308 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 25, 2008 1000 hrs **Medical Examiner** Rogers Donell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5500 Wabash Avenue Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. oreign Months Days Hours Director 1-30-1987 21 20 Country) 219-21-7282 1 X M 2 Yrs Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No s 23a or 28a-f show notified at once. 28a-f shov Baltimore N/A MD Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21205 2630 Ashland Avenue Funeral Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wil
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", or items;
injury or other traumatic event, the Medical Examiner must be.) 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Black Yes f Yes, Give Year Widowed Divorced Specify: Yes 2X No specify: ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Commerical Box Co Elementary/Secondary (0-12) College (1-4 or 5+) Corragated 12th grade l year Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donell E. Rogers <u>Ida Whitworth</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2630 Ashland Avenue Balto, MD 21205 Ida Whitworth- Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 Cremation 3 crematory or other place) 8-1-2008 Randallstown, Memorial Pk KIng Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H Ε. North Avenue Balto, 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease [≂]xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED # 7 per Me G881 7.30.08 TT UNPENDED signed by the attending physician be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown <u>о</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other₄ Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes Inpatient 2 Nursing Home 5 2 No 28a. Date of Injury Jul 25, 2008 After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject was shot 1 Natural 0945 hrs Pending Yes 2 V No within 24 hours after death. To the Funeral Director; completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 5500 Wabash Avenue, Baltimore, MD determined 4 V Homicide (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.F. July 26, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death .^{Day}2008^{ear} July **Physician** 27, 3:20P M Patricia A. Ringgold /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1 Month, Days 9 3 3 5. Social Security Number Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary land 218-28-8026 1 □ M 2 🕅 F 74 Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modeal Examinating to notified at MD 1 ☐ Yes 2√XNo Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1 Smeton Place #1103 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joel Bazzell Beulah Reedy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. Husband 1 Smeton Place #1103 Towson, Maryland 21204 John J. Ringgold / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐XBurial 2 ☐ Cremation 3 Removal from State 7/30/2008 Timonium, Maryland Dulanev Valley Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland Jome 1050 21. Signature of Funeral Service Licensee leter Ruck Towson Funeral Home York Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nontre LVNG CANCES disease or condition resulting in death) /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. It is urbanning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The performed' 1 ☐ Yes 2 🗆 No Division of Vital 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 Mother (Specify) \(\text{NDS OCC} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 6701 N. Charles ST Parson up zing 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) W 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Registrar

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	•	a. Facility Name (if not in: Swallow Falls Sta		e street and number)	'	b. City, Town, or Lo Oakland	cation of Deat		Garrett	
		5. Social Security Number		V 7 A	e /In vrs Is	ast birthday)	If Under 1 Year	If Under 24Hr	rs. 8. Date of Birt	h(MM/DD/YYYY)	9. Birthplace (State or
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte

Division of Vital Records, P.O. Box 68760, C. To the Hospital or Attending Physician: The law requires that the death certificate be executed

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			For State	State of Marylar	nd / Department of h		Mental Hygiene 2008 24311			
	_		Registrar 1. Decedent's Name (First, Middle, Las	#1	Certificate of		Reg. N	lo.	3. Time of Death	
п	Physici		Joseph	99 3	nith	-	Month D	2008	7:40 PM	
-	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death		c. County of Deat		
No.			Stella Mar	is Hospic		onium.			more	
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs	. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Day, Yea	r) 9. Birt	hplace (State or Foreign untry)	
	Director		Usual Residence of Decedent	0.7			lay 10,195	1110	ryland	
	ryland how	L	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits	
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	death with the Maryland	Funeral Director	10e. Street and Number	. 0 . (10f. Zip Code	2 2 3	10g. (Citizen of What Co	Shadas	
	ns 23	eral	5 Fallon Cou	12. Was Decedent Ever in L		236 Hispanic Origin? (Speci	fy Yes or No-	14. Race - Ame	rican Indian,	
9	or iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	If Yes, specify Cub 1 ☐ Yes 2 🛣 No		can, etc.)	Black, White	e, etc.	
5-0036	72 hours after natural", or ite ical Exercitor	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				Specify:	hite	
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2121	withii jiene. r than	l mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse	-,	SA	ate of	Maryland	
b	al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name (First, Middle, Maide	en Surname)		
ylaı	2 should be filed within and Mental Hygiene. is marked other than aumatic event, in the manal of	오	Jack t	Kevec		Jeo	in W	ebb		
Maryland	h and h and 7 is m traum		19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailing Address (Street					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Eventine in safe in notified at once.		20a. Method of Disposition	1 - Spouse 20b.	Place of Disposition (Name of	Dat	ottingha	Location - City or		
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altii	mit. F sartm sortar injur		21. Signature of Funeral Service Licen	1012	22. Name and Addre	of Facility				
ä	permi Depar Impor any ir	l 13	Stani &	Martin	S800 Har	eral Chapt	Parkil	le MD à	21234	
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	1		DR. ERNESTINE WR		ANEY VALLEY RD	TTMONTIM	, MD 210	93		
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	Registr	ar	JUL 29	2008 Menera	A. Branks				<u> </u>	

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 6:30 A M **Physician** Gertrude H. Schmidt 26, July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Ruxton 2027 Skyline Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 □ ¥ 214-14-9989 89 T919 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppartment of Health and Mend lafygiene. Important: If Hean 27 Is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, If a Moster Examiner must be notified at 1 ☐Yes ŽXNo Ruxton Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2027 Skyline Road 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ♣25No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ **¾**Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting 12 <u>Accountant</u> 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental Hv. 17. Father's Name (First, Middle, Last) Be William C. Hohman Sallie B. Reich 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2027 Skyline Road, Ruxton, Maryland 21204 19a. Informant's Name/Relationship *(Type. Print)* Sallie S. Trout Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Glen Burnie, MD 21061 Atlantic Crematory 7/28/2008 4 ☐ Donation / 3 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signaturero Funeral Service Licens 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HEPATOCELLULAR CANCER, METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

2 Hours affect death.

Puneral Director. After this certificate has been signed by the attending physician end letely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Exami AORTIC VALVE DISEASE Box 68760₺ Due to (or as a consequence of) Physician/Medical DIABETES IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🛛 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 252 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 10755 F. 10755 FALLS ROAD, STE 200, LUTHERVILLE, MD CHARLES S. ANGELL, 31. Date filed (Month, Day, Year) State 2008 Registrar

			For State Registrar	State of Maryla	ınd / Depa	artment of F	lealth and N Death	/lental Hy	giene 20 (18 24316
ı	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Ye	
	/Medic Examir		Joseph A. 4a. Facility Name (If not institution, give Saint Joseph	Stefan street and number) Medical C	enter	4b. City, Town, o	r Location of Death		4c. County of E	
	Funeral Director		5. Social Security Number 6. Social Security Number 1. Control of Security Number 1. Control of Security Number 1. Control of Security Number 1. Control of Security Number 1. Control of Security Number 1. Control of Security Number 1. Control of Security Number 1. Contr	ex X) M 2□ F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov 2,		Birthplace (State or Foreign Country) aryland
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	h with	al Di	14209 Quail Cree	k Way, #202		211	52		USA	,
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		American Indian, Vhite, etc.
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Everniner runt be notified at	출	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ∐Yes 2 MX No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specific	hite
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Balt	permit. Pag Department Important: any Injury once.		21. Signature of Funda Cervice (licen	Clera	8	2. Name and Address Lemmon F	uneral Ho	ome of D	ulaney Va	lley Inc.
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8760,4	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons c. CONSTRI Due to (or as a cons d.	CTIVE	PERICAR	DITIS			
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	the Hospital hin 24 hours the Funeral I	Medical	(Check only 2 ☐ Medical Exan	ysician: To the best of my inner: On the basis of examand manner stated.	knowledge, dea nination and/or in	nvestigation, in my	opinion, death occu	e, and due to the urred at the time,	, date and place, and	d due to the cause(s)
	To Vitt	2	29b. Signature and title of certifier			29c. Licen:			29d. Date signed (Month, Day, Year)
			30. Name and address of person who	completed cause of death (I	Item 23a) (Type.		7254		7/2	0/00
	7		BOON POH LIM.	M.D. 760	1 OSLE		. TOWSO	N, MAR	YLAND 21	204
	Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's Sig		1 10 11				

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7-21-2008 **Physician** Year Earl A. Sakowski 12:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 716 Baylor Road Anne Arundel Glen Burnie 5. Social Security Number 6. Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 217-14-9576 Director 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinations be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21061 716 Baylor Road Anne Arundel by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 2 Yes 2 If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify white 1 ☐ Yes 2 🖾 No Specify 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Photographer Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Sakowski Mary Elizabeth Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Scott Sakowski / son 716 Baylor Rd; Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 7-29-2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. Crownsville, MD 21. Signatur of Fuy al Servi 22. Name and Address of Facility Singleton Funeral & Cremation Liceusee Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part (. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed ending physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1XYes 2□No 3 Probably 4 Unknown has been s Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2XNo Hospital: Other: 4 \sum Nursing Home After this funeral dir Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. I or Attending Fafter death. Injury at Work? 1 Nature. 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No ieral Director; # filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, To the Hospital of within 24 hours at To the Funeral D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE \$ 2200, BALTIMORE AD 21237 AUNG, SQUARE SEIN FRANKLIN 9

29c. License number

D-51555

29d. Date signed (Month, Day, Year) 22/2008

State

Registrar

(Check only one)

29b. Signature and title of certifier

and manner stated

MD

, FACP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24318 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 26^{Day} 2008 7:30 Am **Physician** Albert Stern Jack /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 6032 Cherry Avenue 8. Date of Birth (Month, Day, Yea March 14, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. ^{Year)}1924 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. PA 1 XM 2 ☐ F 84 193-19-0900 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tre Medical Experience into the notified #1 1 ☐ Yes 2X No Director Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 6032 Cherry Avenue Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White within 72 hours after 1 ☐ Yes 2 No Specify. Specify: Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Masonry Mason filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental F 7 is marked oth Be Viola Margaret Hockensmith Earl LeFevre Stern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traun 6032 Cherry Avenue Glen Burnie, MD 21061 Mrs. Frances J. Stern/Wife 20c. Location - City or Town, State Aug. Date, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 2008 Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mon Immediate Cause (Final ama Physician disease or condition resulting in death) /Medical Due to (or as a conseque co of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 □No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

n 24 hours after death.

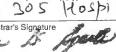
le Funeral Director: Af Hospital within 24 hor **To the Fune** completely fi the

> State Registrar

29b. Signature and title of certifier

Markon 302 2. Registrar's Signature 31. Date filed (Month, Day, Year) 2 9 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

05

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24319 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 200 **EDINA** SPECTOR /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timor N/A If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 0472171930 1 □ M 2 X F Months Days Hours Min PA 183-22-6194 78 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at any injury or other traumatic event, the Marical Examiner must be notified at appear. 10a. State 1 XYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17-A HAMILL ROAD 21210 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian 1 Never Married 2 Married WHITE 1 ∐Yes 2 🛣 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY REAL ESTATE 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be FANNIE SPECTOR VERBIT BENJAMIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5804 RUBIN AVENUE, BALTIMORE, SYLVIA BLOCK / SISTER MD 21215 Baltimore, 20b. Place of Disposition (Name of cample of Crematory or other place)
BETH ISRAEL CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/27/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician LOWER EXTREMITY THROMBOSIS BL VENOUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 months ELL POLYLYWIPHOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 🗆 Unknown 9 Unknown ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 MIN Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director: 2 Accident ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after 4 Homicide e Funeral 29a. Certifier 🞾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JUL 2

9

more, 2401 W. Belvedere Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

A gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Patricia A. Taylor 27 2008 July 8:30 /Medical Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7200 Third Ave, U305 Sykesville Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 132-16-2959 Director 79 DEC 11, 1928 New York Usual Residence of Decedent t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within remove.

the and Mental Hygiene.

27 is marked other than "natural", or items 23a or '

27 is marked other than "natural", or items 23a or '

28 is marked other than "natural", or items 25a or ' 7200 Third Ave, U305 21784 Funeral USA . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify \$ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk Secretary education permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Kilmartin Susan M. Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia T. Salazar/daughter 102420 Little Brick House Rd Ellicott City MD 21042
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc 7/28/08 4 Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring ²² Name and Address of Facility Cremation Society of Maryland, Inc. ods 299 Frederick Rd, Baltimore, M D 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Palmonas Chronic **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of: Examine sician and burial-transit Due to (or as a consequence of): physician Physician/Medical attending | IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 1 ☐ Yes 5 ☐ Other (specify) signed by the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has performed certificate 25**X**No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 247 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician:

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29a. Certifier

Road Eldershuz MD

29d. Date signed (Month, Day, Year)

State

0

Medical

William Tan MD 645 abert 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

To the Hospital

Pt known as: Alvin L. Tucker, S

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh g882 8/4/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Alvin L. Tucker 8:32 PM July 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balt: more Sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□**X**M 2□ F 75 Director 4-6-1933- **1931** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural; or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5640 Groveland Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: Specify African-American 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintence Engineer Bank 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Tucker Charlie Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice W. Tucker/ Wife 5640 Groveland Avenue, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7-28-08 Woodlawn, MD 21. Sign of re of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death Aa. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Ventricular Fibrillation /Medical Due to (or as a consequence of): Examiner Due to or as a consequence of: Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed bunial-transit and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknows 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hyperlipidemia has autopsy performed? 1☐ Yes 2☐ No performe certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D59062 23, 2008 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chad Hanson 2401 W Belvedere 21215 Baltimore MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1	For State Registrar	State of Maryland	-	rtment of H		Re	g. No. U	08 24322
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)	CTrace C	111	man		2. Date of Death	26	Zear J 11:19 P M
	Examin	_	4a. Facility Name (If not institution, give st Sf. [-[1]zabeth	Nuvsing Ce	nter	4b. City, Town, or	Location of Death	^	4c. County	y of Death
250	Funeral Director	Di .	5. Social Security Number 6. Sex	M 2 F 7. Age in yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, JAN 13		9. Birthplace (State or Foreign Country) Ohio
land	MO TH	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Loc	cation				10d. Inside City Limits
ө Мал	Sa-f eh	Director	MD Anne Arui	ndel Gar	mbril.					1 □ Yes 2 No
with th	Sa or 2	Dire	10e. Street and Number 209 Heatherbloom	Trail		10f. Zip Code 21054		1	-	What Country? USA
36 s after death	or iteme 23 animer mus	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Vas Decedent of Hi Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Bla	ce - American Indian, ick, White, etc.
21215-0036 Id within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important; or Iteme 23s or 28s-f ehow important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow any injury or other traumatic event, It a Medical Examinat must be notified at once.	Completed b	15. Decedent's Educ (Specify only highest grade		(Give life. D	DO NOT use retired	during most of wor	kıng		Business/Industry
d 21	Hygien ther th int, the	Con	12 17. Father's Name (First, Middle, Last)		Homei	maker	18. Mother's Nar	ne (First, Middle, I		
rlan	dental irked o itic eve	To Be	Frank Gee				Minnie		Clar	
Maryland of the	7 is ma reauma		19a. Informant's Name/Relationship (Type		200	g Address (Street Heather)	and Number or Ru bloom Tra	ral Route Number 111, Gamb	city or Town	n, State, Zip Code) MD 21054
re, I	f Healt item 2 other	1	Barbara L. Castella 20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of natory or other plac		_		- City or Town, State
Baltimore,	ment o tant: If jury or		1 A Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	St.	Jose	oh's Cem.	8/2/	_	Palm Ba	ay, FL
Balt Permit.	Depart import any in		21. Signature of Funeral Service License	eorge E. MacNat	ob 2	Name and Addres MacNabb F 301 Frede	of Facility Funeral H Erick Roa	ome, P.A d, Caton	sville	, MD 21228
	nysician Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Due to (or as a conseque)	kin	er the mode of dyir	diseas-	و		Approximate Interval Between Onset and Death
	xaminer	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or at a conseque	rren	t eer	ebral	vascula	w acc	cident years
760, 7		ical Examiner	resulting in death) Last	Due to (or as a conseque	nenof):	y art-	ery di	's ease		years
Records, P.O. Box 68 The law requires that the death certifica	igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregnanc	у			late of delivery Month Day Year
ds, P.	signed by	þ	Part II. Other significant conditions con	tributing to death but not result $arphi \mathcal{N}$	ing in the u	nderlying cause giv	ven in Part I.	23e. Did to	10	ntribute to the cause of death?
Division of Vital Records, or Attending Physician: The law requires t	ate has been si page 2 should	Completed	the pothyroi	dism		-		24a. Was a autop perfor	sv	. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)
of Vita	certific rector,	Be	25. Was case referred to medical examiner?	lospital:		- Ott	L 10	ath (Check only of		Mh = 2 (C=== 44)
Vision of Attending Phys		ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 El	PVOutpatier 28b. Time of Injury	f 28c. Inju	4/A Nursing r	Home 5 ☐ Resid		
Divis	after des Director d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Tow		nber or Rural Route Number,
Div	n 24 hours ne Funera	edical C	29a. Certifier 1 VCertifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knowler: On the basis of examination and manner stated.	ledge, deati on and/or in	h occurred at the to vestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and r date and place	manner as stated. e, and due to the cause(s)
To the	withir To th comp	Me	29b. Signature and title of certifier	m Chr	0	29c. Licen	se number	1	29d. Date sign	2P, 2008
	3		30. Name and address of person who co	impleted cause of death (Item 2	23a) (Type, AU €	Print) MUL,	Baltin	nore,	Mary	28,2008 land 21227
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 9 2008	52. Registrar's Signatu	Ire Park	de			/	

State Registrar

31. Date filed (Month, Day, Year)

DENNIS

29b. Signature and

title of certifier

HOUSE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



ORIGINAL

MD

DFFICER

29c. License number

RES O O O 1

29d. Date signed (Month, Day, Year)

JUL

		-	For State Registrar	State of Maryland		rtment of tificate of			giene Reg. No. 2111	8 21.321.
			Decedent's Name (First, Middle, Last)					2. Date of De	ath Day Year	3. Time of Death
	rysicia Medic			Albert	Wade			Valy	24 2008	2353 M
	xamin		4a. Facility Name (If not institution, give	treet and number),		4b. City, Town,	or Location of Dea	th	4c. County of Dea	ath
			Good Samanita	n Haspital	a A to hadboring a	If Under 1 Year	more r I If Under 24 Hr	s. 8. Date of Bir	NA th 9 Bi	rthplace (State or Foreign
	neral ector		5. Social Security Number 6. Sex	7. Age (In yrs. la	Yrs.	Months Day		. (Month, Da	6–1934	N . C .
	ctor		237-52-3253 Superior State of December 1	74				0-2	0-1934	
ryland	11		10a. State 10b. County MD		Town or Lo					10d. Inside City Limits 1
e Mai		Director	FID	N/A Do	altim				4110	
vith th	DE NO.	Ö	10e. Street and Number 3612 Bellevale	Arronno		10f. Zip Code	21206		10g. Citizen of What C	country
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	inust Funst	Funeral		12. Was Decedent Ever in U.S	3. 13. \			Specify Yes or No		nerican Indian,
fter d	in the	표	11. Marital Status 1 ☐ Never Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			f Hispanic Origin? uban, Mexican, Pue	rto Rican, etc.)		
21215-0036 d within 72 hours aff giene.	Exem	ò	3 Widowed 4 Divorced	If Yes, Give** Year or Dates:		1□Yes 2√1	lo Specify:		Specify: E	Black
5-0	dical	Completed	15. Decedent's Edu (Specify only highest grade	cation a completed)	(Give	dent's Usual Occ kind of work dor	ne during most of w	orking	16b. Kind of Busines	s/Industry unk
within ene.	M a	ld III	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	Op	erator		
filed v	aut, it		12th grade 17. Father's Name (First, Middle, Last)	N/A	н	eavy E	quipmen 18. Mother's N		, Maiden Surname)	
ld be lental	ic eve	To Be	Sam Wade				Eln	a Brow	n	
Maryland of 2 should be file Ith and Mental H	umat	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Stre	et and Number or	Rural Route Numb	per, City or Town, State	, Zip Code)
e, M 1 and 2 Health	er tra		Katherine Wade	-Wife	36	12 Bel	levale .		Balto, MI	
Baltimore,	Important, it tent 27 is marked other trian matural, on tents 250 of 250-1 show any Injury or other traumatic event, the Modical Exeminer must be notified at once.		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ F	C6	emetery, crer	sition (Name of natory or other p		Date	20c. Location - City of	
Limor Pages tment of	jury		4 Donation 5 □ Other (Specify)	K:					Randalls	
Baltii permit. F Departm	any In		21. Signature of Funeral Service Licens	ne 1	22	2. Name and Ad		March	•	
	- 10 01		23a. Part 1. Enter the disease, or compl	cations that caused the death	Do not ent				e Balto,	Approximate
		8 6	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			10	1. 4		Interval Between Onset and Death
Physi Me/	ician dical		disease or condition resulting in death)	Due to (or a /a consequ	ience of):	as .	in juice	fine	Disease	1 Hour
Exam	niner			Attiers sel	wite	c Ca	relivas	enlor	idisease	YEER
g	.=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):	~~				
ecute	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a bisequ	rfens	run				year!
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587 ficate	s the	edical		1.						
Box (eath certi	for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7=			23d. Date of	
Geath	d for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d		☐ Ectopic pregn ☐ Other <i>(specify</i>			Month	Day Year
P.O.	tache	hys	9 Unknown	9 Unknown				00. PM	A-1	e to the cause of death?
S, es the	d be detached for	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	inderlying cause	given in Part I.			Probably 4 Unknown
Vital Record sician: The law require	should	Completed								
e law	e 2	nple.					-	– 24a. Wa auto per	s an 24b. Were prior formed? death	autopsy findings available to completion of cause of
al F	ector, pag		OF Management and to madical				00 Diversit	1 □ Yes	2 🗹 No 1 □ Y	es 2 No
Vit		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🗂	EB/Outpatie	nt 3 🗆 DOA	Othor	eath <i>(Check only</i>	sidence 6 Other (S	Specify)
of of of	funeral di	n: T	27. Mann of Death	28a. Date of Injury	28b. Time o		njury at Vork?		how injury occurred	,
ion ath.	e fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		1 ☐ Yes 2 ☐ No			
Division of all or Attending Phy after death.	in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, offi	ce	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certificates the European Diverse that the Control Diverse the Control of th	completely filled in by the							N .		r ac stated
Hospital	rune stely fi	Medical	29a. Certifier 1 CertifyIng Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno Iner: On the basis of examina and manner stated.	wledge, dea ition and/or i	th occurred at the nvestigation, in r	ne time, date and pi my opinion, death o	ace, and due to tr ccurred at the time	e, date and place, and	due to the cause(s)
To the Hospital within 24 hours	omple	Mec	29b. Signature and title of certifier	1		29c_Lic	ense number	,	29d. Date signed (M	onth, Day, Year)
H 5 H	- 0		* Klumuth y	E_		1	13959	13	July 2	5, 2008
1	3		30. Name and address of person who c	mpleted cause of death (Iten	n 23a) (Type	, Print)	-/ /	1/ -	7 1/	s, rove
2			KOVIN It. Serve			umar	tan 1	parted	bultimor	s Maryland
,	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Gara				

DHMH 17 Rev 1/2001

Wade Albert

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July 23° 2008 5:45 am Dolores Herman Woolford 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Woodlawn 3407 Keston Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)
June II, 5. Social Security Number 7. Age (In yrs, last birthday) Days Hours 1 □ M 2 🕸 1934 Mary Land 74 219-30-3016 Usual Residence of Decedent 10d. Inside City Limits 1∩a State 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Woodlawn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21207 3407 Keston Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 X Married Specify: Black 1 □Yes 2 XNo Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Dorothy Hill Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3407 Keston Road, Woodlawn, Maryland 21207 Husband Ernest Woolford Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place)
4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery July 31, 2008 Owings Mills, MD 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licenses 8728 Liberty Rd., Randallstown, MD 21133-4784 alleon H00333 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 years static disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner Examiner

and burial-trar

attending physician

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funeral director, page 2 should

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After

24 hours after death. Funeral Director: A

within 2 To the I

filled in by

completely

Physician/Medical

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Completed

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm McJical Examiner must be notified at

Sequentially list conditions, if any, leauning to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

> 1 ☐Yes 2 No 26. Place of Death (Check only one)

> > 28d. Describe how injury occurred

2 No 1 ☐ Yes

25.	Was case examiner?		to medical
	1∐ Yes		
27.	Manner of	Death	

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural
2 Accident

3 Suicide

4 Homicide

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orleans Street, Baltimore Maryland 21231 M.D. 200 8³². Registrar's Signature

Approximate Interval Between Onset and Death

MD 21502

MD

2008

0850

10d. Inside City Limits

Y☐Yes 2☐No

9. Birthplace (State or Foreign

ŴD

certificate has b irector, page 2 s director. n 24 hours after death.

The Funeral Director: A pletely filled in by the

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Completed

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Certification:

Medical

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in the past 12 months? 1 ☐ Yes 2 **X**No 9 ☐ Unknown

25. Was case referred to medical

examiner' 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

29a. Certifier

2 Accident

(Check only one)

23b. Was decedent pregnant

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24a. Was an

1∐ Yes

26. Place of Death (Check only one)

autopsy performed? Yes 2 No

Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

ATRIAL FIBRILLATION

5 ☐ Pending investigation

1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the cause of examination and or investigation and or Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D0064167

AVE

29c. License number

29d. Date signed (Month, Day, Year) 07 22 08

QUINBERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOSHIN GAISRAMI

M.D. 50 32. Registrar Signatur 500 MENORIAL

N. Cair vain mo

State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #18&19a per FH G883 9/04/08 Jh Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2008 11:46 AM Robert L. Aspeslagh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day) Days Virginia XX M 2 D F Yrs. Jan. 1929 Director 228-26-9602 79 20, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examination outstown outfled at 1 ☐Yes 2☐No Directo Maryland | Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 may be a should be United States 517 Laurel Road 21140 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: 3 Widowed 4 Divorced White 1954 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transformer Tester Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) Be Louis M. Aspeslagh Beatrice Hanerty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City o 21 1/44 ate, Zip Code) Helen M. Aspeslagh / Wife 517 Laurel Road Riva, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/11/2008 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Funeral Service-Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Souter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) SON CO /Medical Due to ras a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a solisequelise of) law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part LOther significant conditions contributing to death but not resulting to the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been si 2 □ No 3 robably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar certificate has autopsy performe

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Completed Be Certification: To funeral c

1 ☐ Yes 26 Place of Death (Ch

1 ☐ Yes 2 No

25. Was case reference	rred to medical				26. Place of Dea	th (Check onl. one
	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	X	OA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Dea 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	- 1	28c. Injury at Work? 1 ∐Yes 2 ∏No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, fa	actor	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier	1 ertifying Ph	vsician: To the best of my kn	owledge, death occi	urrec	d at the time, date and place	e, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies

29d. Date signed (Month. Day, Year)

JUL 1 4 2008 31. Date f

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of death (Item 23a) (Type, Print)

State Registrar

Medical

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			For State Registrer		State of Ma	aryland		rtment o			Mental Hy	ygien Reg. N	201	8 (24	329
			1. Decedent's Nam	ne (First, Middle, Las	st)						2. Date of D	eath		V	3. Tim	e of Death
	Physic /Medi		Arthur	LeRoy	Abbott						July		ay - 201	Year O.S.	12	:35a
7	Exami				street and number)					ocation of Death	1 -	4	c. County	of Death		•
			Long V	lew Nur	sing Home	е		M	lanc	chester	:		Car	roll	-	
	Funeral Director		5. Social Security 1 212-09-		ex 7.Age 12⊒M2□F	9 (In yrs. Ia	st birthday) Yrs.	If Under 1 \ Months D	Year Days	If Under 24 Hrs. Hours Min.	(Month, D			Cour	ntry)	ate or Foreig
			Usual Residence of			96					Aug	15 1	911	M	ID	
	yland now		10a. State	10b. County		10c. City,	Town or Lo	cation						1	Od. Insid	le City Limit
	deeth with the Maryland me 23a or 28a-f ehow rmet be notified at	tor	MD	Baltim	ore	Ţ	Jpper	CO							1 🗆	Yes & N
	or 28	Director	10e. Street and Nu	mber				10f. Zip Co	ode			10g. C	itizen of W	/hat Cour	ntry?	
	23a	al C	16357	Trenton	Road			211	55					USA	1	
98	efter dee or Iteme	/ Funeral		ried 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X			Vas Deceden Yes, specify ☐ Yes 2√2		panic Origin? (S Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	10-	Blac	e - Americ k, White, : whi	etc.	n,
21215-0036	hours efter tural', or Ite	ed by	3 🔀 Widowed	4 ☐ Divorced 15. Decedent's Ed	Year or Dates:							1.05				
5.	in 72 nan 'n	Completed		cify only highest gra	de completed)		(Give i	ent's Usual C kind of work o OO NOT use i	done du	on ring most of wor	king	160.	Kind of Bu	siness/in	austry	
212	within iene. r than	E	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)		mber	,				n'	lumb	nina	
	illed Hygother other	Bec		(First, Middle, Last)					1	8. Mother's Nan	ne (First, Middle	e, Maide				
<u>a</u>	should be nd Mental markad matic ev	ToB	Willi	am Carl	Abbott					Florer	ice Vi	rgir	nia 1	Myer	S	
Maryland	nd 2 :	-		www.Relationship (Type, Print) h, daught	ter				d Number or Ru Road,						
ore,			20a. Method of Dis	•	S	20b. Pla	ce of Dispos	sition (Name	of r place)	1	Date	20c. l	Location -	City or To	own, Stat	θ
altimore,	Peg ment ant: f ury o			5 Other (Specify	•	Tre	enton	Ceme	ter	y 7/1	8/2008	Up	pper	co,	MD.	
Baj	permit. Depertrimports imports any inj		21. Signature of Fe	uneral Service Licen	\mathcal{L}	0072	1 22	Name and A	Address	of Facility E1	ine Fu	inei	cal I	Home)	
	40344		Dan	da of o	Lemme		19	34 S.	Ma	in St.	, Hamp	oste	ead,	_Ma.	21	
			snock, or nea	an failure. List only	olications that caused one cause on each lin	the death. ie	Do not ente	or the mode o	f dying.	such as cardiac	or respiratory	arrest,			Approx Interval	mate Between and Death
,	Physician		Immediate Cause disease or condition resulting in death)	on	a. ay	heir	ness	Di	se	asl				/	04	III Doalii
1	/Medical Examiner		resulting in death)	(Due to (a d)	a conseque	ence of):)	0 6	E. F.					1	
		5	Sequentially list co	enditions,	b. Due to (or as a	MIL	non of):	enu	-	Farture					54	~
	ted nsit	nlu	if any, leading to in cause. Enter Under Cause (Disease or	ertying	Coras	. L	illed (il).	e sit	F	a lan				2	-, /	
	cate be executed physicien end the buriel-transit	Examine	that initiated events resulting in death)	S	c. Due to (or as a	1)conseque	ence of):	cr-u	10					-	y	_
8760,	cate be execu ohysicien end the buriel-tra	dical		· ·	4										•	
68	ificate g phy as the	edic		_	d											
Вох	deeth certific e ettending p id for use as	Completed by Physician/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome								23d. Date	e of deliv	өгү	
	0 0 0	Cla	in the past 12 1 ☐ Yes 2 8		1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregr Other (special					Mor		Day	Year
P.0	that the de ad by the deteched	hys	9 Unknown		9□ Unknown											
	The law requires thet the rite bas been signed by the bage 2 should be deteched.	oy P	Part II. Other signif	ficant conditions co	ontributing to death bu	ıt not result	ing in the un	derlying caus	e given	in Part I.	23e. Did	tobacco	use contr	ibute to th	he cause	of death?
Ď	w require been sig should b	ed									1	Yes :	2 □ No	3 Prob	oably 4	Onknow
Records,	e law re hes be je 2 sho	plet									24a. Wa		24b. V	Vere auto	psy findi	ngs availab
Ř	The ste he	E									peri 1 Yes	opsy formed? 2/2 N	d d	leath?		of cause of
Vital	ysician: The l is certificete he director, page	Be	25. Was case refer examiner?	red to medical					2	26. Place of Dea	7.0	17.77			20.40	
>	Physician: this certific ral director,	101	1 Yes 2	No	Hospital: 1 ☐ Inpatier	nt 2 E	R/Outpatient	3□ DOA	Other:		ome 5 Res		6 □Othe	or (Specif	(y)	
0 0	ng Pt fter th		27. Manner of Deat	h 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c.	Injury a Work?		28d. Describe					
Sio	Attending r death.	atic	1 Natural 2 Accident	investigation			,,	М		s 2 □No						
Division of	i or Att	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju	ry - At hom . (Specify)	e, farm, stre	et, factory, of	ffice		28f. Location City or To			er or Aura	al Route	Number,
	oitaí c urs af rai D															
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)	2 Medical Exem	vsicien: To the best of liner: On the basis of and manner sta	examinatio	edge, death in and/or inv	occurred at t estigation, in	he time, my opir	, date and place nion, death occu	, and due to the rred at the time	e cause(e, date a	s) and maind place, a	nner as s ind due to	tated. o the cau	se(s)
	To To	2	29b. Signature and	title of certifier	n 11	1_1	1.0	29c. Li	cense r	number		29d. D	ale signed	Month,	Dey, Yea	ar)
	WJ-73		Plan	mW.	mid	ilm	YND) 2	17 4	43	/	119	120	008	
	6		30. Name of addr	ess of person who o	completed cause of de	ath (Item 2	23a) (Type, F		,	Man	11.	-				
		_!	31. Date filed (Mon	th Day Your	yon 3337	VIC	tory.	Stree	7	1 - 10-11	west	4	m I	141	02	
	Sta Registr		OT. Date filed (MON		32. Resettra		k	hore								
DH	MH 17 Rev 1/2			JOLIO	LUUU Juga	w,	1 /g	Dela)						-		

08-05291 Marquan Andrews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24330

	1- For State Registrar	Certificat	e of Death	Reg.	Z U U No.	0 24000
Physiciar	Decedent's Name (First, Middle,Last)	ANDRESIG		2. Date of Death Month D	ay Year	3. Time of Death
ledical Examin		ANDREWS		July 9, 2008	4c. County of Death	2247 hrs
	4a. Facility Name (if not institution, give stree Prince George's Hospital Center		4b. City, Town, or Location of D Cheverly	eatn :	Prince George	L L
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		4Hrs. 8. Date of Birth(AM/DD/VVVVI 9 Birt	bolace (State or
Director	242-67-2430 ₁ X _M			Min. APRIL 1	9 1990 Foreig	NORTH CAROLINA
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
*	MD PRINCE GEO	RGE'S CAP	ITOL HEIGHTS			1 X Yes 2 No
faryland	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
the M is or 2		AD #C1	20743		USA	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Tiem 27 is marked other than "natural", or items 23a or 28a-f she rtraumatic event, the Medical Examiner must be notified at once	11. Marital Status		3. Was Decedent of Hispanic Ongin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ifter d	3 Widowed 4 Divorced If Yes	Give Year	1 Yes 2 X No specify:		Specify: B]	LACK
ours a atura		nest grade completed) 16a. De	cedent's Usual Occupation (Give kind ring most of working life. DO NOT use		6b. Kind of Business/	ndustry
5-0036 led within 72 hou Hygiene. lother than "nat the Medical Exa	*	ollege (1-4 or 5+)		s retired)		
5-0036 iled within 72 Hygiene.	12th		MAINTENANCE	lame (First, Middle, Mai		RNMENT
21215-00 uld be filed will be filed will marked other c event, the M	DARRYL HARDWICK			rractna and		
Should be fill and Mental F. is marked natic event,	19a. Informant's Name/Relationship (Type, F		Mailing Address (Street and Numbe			, Zip Code)
MD d 2 sho lth and n 27 is	YOSHIDA JACKSON/GUA	RDIAN 69	06 WALKER MILL RI	# C1 CAPI	TOL HGTS,	MD 20743
ore, MC es land 2 st of Health an If item 27 i her trauma	20a. Method of Disposition		Disposition (Name of cemetery, or other place)	Date 2	20c. Location - City or	Town, State
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	1 XBurial 2 Cremation 3 Records Other Specify:		ECTION CEMETERY	7/17/2008	CLINTON, M.	ARYLAND
alti mit. partm porta	21. Signature of Funeral Service Licensee	4	22. Name and Address of Facility	J. B. JENK	INS FUNER	AL HOME
0 50 5 5	I Wall Treaser		7474 LANDOVER			
Physician /Medical	23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ns that caused the death. Do not e e.	enter the mode of dying, such as card	liac or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)			4		Death
	, Duc 10	o (or as a consequence of):				
	Sequentially list conditions.	o (or as a consequence of):				
	if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last	(or as a consequence of):				
cuted nd transit		(or as a consequence or).				
760, cate be executed physician and the burial - transi	UNPENDED AM IF FEMALE: 23	ENDED				
760, icate by physic the bun	IF FEMALE: 23	c. If yes, outcome of pregnancy			23d. Date of deliver	у
x 687 h certific tending use as t	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pr	regnancy	Month	Day Year
Box e death c the atten ed for us	Day 12 yes 2 No 9 Unknown 9 Part II. Other significant conditions continued to the significant conditions conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued to the significant conditions continued	Unknown	Other (Specify)	Y	1	- 10
		ibuting to death but not resulting i	n the underlying cause given in Part I	. 23e. Did toba	acco use contribute to	the cause of death?
ires that the signed by the detaction	<u></u>			1 Yes	2 No 3 Pro	bably 4 Unknown
of Vital Records, ng Physician: The law require ufter this certificate has been si meral director, page 2 should b	B			24a. Was an autopsy		utopsy findings available completion of cause of
eco ne faw te has ge 2 sl		-		perform	ed? death?	
tal Recian: The			26.Place of Death (Cl			2 10
Vita ysicia his.ce	25. Was case referred to medical examiner? Hospit Very Sample of Death	al: 1 Inpatient 2 🗸 ER/Out	patient 3 DOA Other;	lursing Home 5 R	esidence 6 Othe	er:
of ng Ph	27. Manner of Death	8a. Date of Injury 28b. Til	me of Injury 28c. Injury at Work?	28d. Describe ho Pedestrian st	w injury occurred	
ion teath. tor: ,	1 Natural 5 Pending 2 Accident Investigation	Jul 9, 2008 2200 I	nrs 1 Yes 2 ✓ N	o Fedestilaii st	ruck by auto	
Division tal or Attendii rs after death. ral Director: A	3 Suicide 6 Could not be		n, street, factory, office building, etc.	or Town, Sta	te)	ural Route Number, City
Division spital or Attent hours after death meral Director: y filled in by the		(Specify) Major Road / Hig	hway	Southbound Ro	ute 210 at Talbert	Drive, Fort Washingto
Di To the Hospital within 24 hours a To the Funeral I completely filled	Certifying Physician: T	o the best of my knowledge, death ne basis of examination and/or inv	n occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cause(rred at the time, date ar	s) and manner as stand place, and due to t	ted. he cause(s)
To To To To	29b. Signature and title of certifier	manner stated.	29c. License number		29d. Date signed (M	
(2)	Don har I int	- 1 mcD	O.C.M.E.		July 10, 2008	
de	30. Name and address of person who compl	eted cause of death (Item 23a)				
De		stant Medical Examiner	111 Penn Street, Baltimore	e, MD 21201		
	(e 31. Date filed (Month, Day, Year)	32. Registrar's Signature	-			
Registra	ar JUL 1 5 2008	K had				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygien ?

21,331

					Certificate o	f Death		Reg. No.		24331
Dhyo	inian	1. Decedent's Name (First, Middle, La	est)				2. Date of De Month		Vaca	3. Time of Death
Phys /Me	ıcıan dical	KENNETH EDWA	RD BERRY					22,200	Yeer 8	6:15P
Exan		4a. Fecility Name (If not institution, gir	e street and number)			4b. City, Town, or L				
		SOLOMONS NUR	SING CENT	rer		SOLOM	ONS	CALV	TOT	
Funer	al	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birth	day) If Under 1 Yea	r If Under 24 Hrs.	8. Date of Bir	th Voor)		ace (State or Foreign
Directo	or.	215-34-3187	M 2DF	73 Y	rs. Months Dey	s Hours Min.	8. Date of Bir (Month, Da 8 – 10 –	1934	MD.	ry)
P >		Usual Residence of Decedent 10a. State 10b. County								
eryta shov	_		рш	10c. City, Town					10	od. Inside City Limits
188-f	Sch	MD. CALVE	K I		OWINGS					1 ☐ Yes 2 TXNo
Vith t	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Whet Count	ry?
ath v	E E	8805 PARIS E				0736		U.S.A.		
ar da	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac	e - America k, White, e	
Q Z1Z15-UUZU filed within 72 hours ofter death with the Meryland Hygiena. ther then "neturel; or Items 23a or 28a-f show ant, the Medical Exeminer must be notified at	Ş	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N	O ARMY	1 □ Yes 2 □ XN				WHIT	
			Yeer or Dates:		••					
21215-0020 d within 72 hours of giena. If then "neturel; or the Medical Evans	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		Decedent's Usual Occ Give kind of work don life. DO NOT use retii	e during most of work	ring	16b. Kind of Bu	usiness/Indi	ustry
than a	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	STORE O	•		SELF I	PMDT C	VAED
filed that		12 17. Father's Neme (First, Middle, Lest	}			18. Mother's Nam	e (Einst Middle			7120
Maryland d 2 should be file th and Mental Hy 7 Is marked otha	Be	MITTER TANK TO	'	RΥ			A. MO		16)	
should of Men marks	ို	19a. Informant's Name/Relationship (Mailing Address (Ch.				O . T	0.41
IVE, MATYIANG 21215-0020 Is 1 and 2 should be filed within 72 hours efter death with the Merylan of Health and Mentel Hygiena. It marked other than "natural, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		CYNTHIA L.BERR				et and Number or Rur				•
ore, not haalth litam 27		20a. Method of Disposition	I-DAUGHIE		510 ACTO	N LANE V	VALDOR.	F MD. 2 20c. Location -		
Pagas Pagas nant of int: If Ita		1 ☐ Burial 2 ☑ Cremation 3 ☐		cemetery	crematory or other p					III, Otalo
르 글론원은		4 ☐ Donation 5 ☐ Other (Specifical Service Liceron Signature of Funeral Service Liceron Servi				MATORY 7-	-24-08	ALEX.	VA.	
Depen Day		21. Signature of Purieral Service Licer	M0047	9 ()	22. Name and Add RAYMOND	FUNERAL	SERVI	CE.PA		
		fielent	/ Xx		LA PLATA	A,MD. 206	546		•	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause beech lin	the death. Do no	t enter the mode of dy	ying, such es cardiac	or respiratory e	rrest,		Approximate Interval Between
Physician	-		, A	- 1	/					Onset and Death
/Medica Examine		Immediate Ceuse (Final disease or condition resulting in death)	a. 6/1/	9, C17	10021Z					
	1 5	rooming in doubly		Due to (or as a co	nsequence of):				1	
≥ ted ×	Medical Examiner		b		-				I	
be axecuted slcian and buriel-transit	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or as a co	ns o quence of):					
filicata be axi physician as the buriel.	<u> </u>	Cause. Enter Underlying Cause (Disease or injury that initiated events	c						i	
phy:	듛	resulting in death) Last	ſ	Due to (or as a co	nsequence of):				į	
that the daath cartifiad by the ettending ad by the ettending datached for use et		L	d							
daath daath a ettan	Physician			The state of the s	_					
the d	lys.	Pert II. Other eignificant conditions of	ontributing to death bu	t not resulting in t	he underlying ceuse g	iven in Part I.	23b. Did 1			the cause of death?
that that	1	Deletes Mb	11/4/5				10	Yee 2□ No	3 🗆 Probe	ably 4 tonknow
w raquires that s baan signad b	d by	11					240 Wee	en eutopsy	24h Wei	re autopsy findings
200	ete	HyphypM5/4	m				perfo	med?	avei	ilable prior to
ha ya	Completed	Jacob A.	•				i			leath?
icien: The i cartificata ha	ပိ	COPD					101	res 2⊠No	10	Yes 22/No
Physicien: The this cartificata ral diractor, pag	Be	25. Was cese referred to medical examiner?	Hospital:			26. Place of Deat	h (Check only o	ne)		
al this	1.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatier		atient 3 DOA			dence 6 □Oth)
Affar funa	<u>6</u>	1 ☑Naturel 5 ☐ Pending	(Month, Day	y Year) 28b. Tir Inji	ury W		28d. Describe !	now injury occurr	ed	
Attanding ar daath.	cal	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2□No	00(1 // //	2		
or A aftar Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, street, fectory, office	•	City or Tov	Street and Numb vn, State)	er or Hurai	Houte Number,
pital ours aral fillad		29a. Certifier 1 Certifying Ph	veicles. To the heat of	f mar lengual order						
To the Hospital or Attanding Phys within 24 hours aftar death. To the Funaral Director: Aftar this completely filled in by the funaral director.	edical	(Check only 2 Medicel Exam	ysiclen: To the best of niner: On the basis of end manner state	examination end/	or investigation, in my	opinion, deeth occurr	and due to the e	cause(s) and ma date and place, a	nner as sta and due to	neo. the cause(s)
o the o the ompl	₹	29b. Signature and title of certifier	One mainer sta		29c. Licer	nse number		29d. Date signed	d (Month. D	Dey, Year)
⊢≯⊨ŏ		10 - hon	- Wak		N = -	3//5//-7		0 > /	2 7/	50
1.		30 Namo and address	9,1VD	-4-//4 :	DOG	7/133	(1/10	15/	00
YX,		30. Name and eddress of person who	completed cause of de	atry (Item 23a) (T	(perPrint)	I Fallas	h m	1 20	15	8
,	ate	31. Date filed (Month, Day, Year)	32. Registra	TUL / Kd	17 KARL	1 Hallu	CK) IL	DONE		0
Regis		1111 0 0 2000	le de la la la la la la la la la la la la la	14 Ano	AP. 3					
NAME TO DAY O		10 % 3 A A A A A A A A A A A A A A A A A A	J. 58 18 18 18 18 18 18 18 18 18 18 18 18 18	15. JESTER	100	·				

08-05655 Raymond Howar	d Ba	Please Type or Print in Black Indelible Ink. Ensure All Copartles, Jr. State of Maryland / Department of Health and Mental		ible.	
		For State Certificate of Death	Reg	j. No2008	2433
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) Raymond Howard BARTLES Jr.		Day Year	of Death 8 hrs
y 4.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec		4c. County of Death	
)		Easton Memorial Hospital Easton	U. Doto of Birth	Talbot (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		Months Days Hours	Min	Foreign	laryland
	-	218-82-0829 1X M 2 F 43 Yrs. Usual Residence of Decedent	Aug. 2	0 1904 5557/11	aryrand
w any		10a. State 10b. County 10c. City, Town or Location			side City Limits Yes 2 No
yland a-f sho	횽	Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code		g. Citizen of What Country?	163 2 110
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumante event, the Medical Examiner must be notified at once.	Funeral Director	807 W. Washington Street 21740		USA	
n with t	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-		an, Black,
r death	Fun	1 Yes 2X No	isito radan, etc.,	Specify: White	
urs afte tural",	ā	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/Industry	
5 72 hor an "na	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	e retired)		
003 Within grene. her tha	Completed	10 0 None 17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle, M	None	
215- e filed tal Hyg ked oth			ey Ann Ard		
MD 21215-0036 d 2 should be filed within 72 hours thand Mental Hygiene. n 27 is marked other than "natur unnaric event, the Medical Exami	5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			de)
nd 2 shad 2 sealth ar	1	Faith Bryan - Sister 807 W. Washington S 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Street, Ha	gerstown Md. 20c. Location - City or Town, S	21740 State
Baltimore, permit Pages I an Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		·	
ultim nit Pa artmen oorfaul	1	4 Donation 5 Other Specify: Hagerstown Crematory 7 21. Sign and Funeral Service Licensee 22. Name and Address of Facility		<u>Hagerstown, Ma</u> Funeral Home	aryland
Ba Perr Dept Injuri	. ,	Scott M. Munne 415 E. Wilson BI	lvd. Hager	stown, Md. 217	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.		Betw	oximate Interval ween Onset and Death
-xaminer		$\begin{array}{llllllllllllllllllllllllllllllllllll$	pertensive	1	- Deau
		Sequentially list conditions, b.			
	jue	if any, leading to immediate cause. Enter Underlying Cause c. Due to (or as a consequence of): c.			
11/4 = E	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al-transit	ical	X UNPENDED	ГТ		
tox 68760, eath certificate be attending physici for use as the buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
certific	sician/Med	23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pr	regnancy	Month Day	Year
Box 68760, re death certificate be the attending physic red for use as the bur	Physi	1 Yes 2 No 9 Unknown g Unknown			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		bacco use contribute to the causes 2 No 3 Probably	
rds, require been si	Completed		24a. Was		
of Vital Records ing Physician: The law requ After this certificate has been inneral director, page 2 should	omp			rmed? death?	2 No
Vital Rec ysician: The l his certificate l	BeC	25. Was case referred to medical examiner?			
f Vit	P	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA		Residence 6 Other:	
on of \nding Phy tth. r: After the	io.	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 1 Yes 2 No.		,,	
Divisior pital or Attent ours after death teral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Rural Rou	ite Number, City
Di Hospital 24 hours a Fruneral U	Cert	4 Homicide determined (Specify)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	e, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause	e(s)
To To	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Da	ıy, Year)
0		O.C.M.E.		July 24, 2008	
OCME		30. Name and address of person who converted cause of seith (Item 23a) Mary G, Rippie MD. / Deputy Chief Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
<u></u>	ate	31. Date filed (Month, Day, Year) 38 Registrar's Signature			
Regist	rar	JUL 2 9 2008 Bloom & Brance			

2

State Registra

Assistant Medical Examiner Russell Alexander MD. istrar's Signature 32. F

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

DCME

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John David Bell, Sr. State of Maryland / Department of Health and Mental Hygiene 2008 24334 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 9, 2008 1542 hrs Medical Examiner John David Bell, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 12745 Holiday Lane Bowie If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Hours 08/22/1935 Director 232-54-8203 72 Country) 1 X M 2 F PA Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No or 28a-f show tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at once.</u> Prince George's Bowie 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number nit. Pages 1 and 2 should be filed within 72 hours after death with the 1 virtuant of Health and Mental Hygiene.

virtuant: If item 27 is marked other the "..." USA 12745 Holiday Lane 20716 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married Yes 2 X No specify: White Specify: If Yes, Give Year 1955-58 Widowed Divorced <u>م</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Electrician 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Louise Minger William Joseph Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12745 Holiday Lane Bowie, MD 20716 Catherine Z. Bell / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State filmore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimo permit. Page Department o Important: 7/15/2008 Crownsville, MD MD Veterans Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Neck Injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed hysician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? page 2 2 No ✓ Yes 2 No 1 🗸 Yes Attending Physician: death. 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Other₄ DOA Nursing Home 5 Residence 6 ✔ Other: Scene this Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject fell down steps FOUND Natural 1 Yes 2 ✔ No Pending ay the Jul 9, 2008 1538 hrs 2 🗸 Accident Investigation To the Hospita or At within 24 hours after d 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 12745 Holiday Lane, Bowie, MD determined (Specify) residence 4 _ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. July 10, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registra

32. Registrar's Signature

Tafiled (M5)th 2008 ear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and M Certificate of Death		ne No 2008	24335
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
~	/Medic	cal	Suzanne Michelle Blanchett 4a. Faeility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	701	, , , , , , , , , , , , , , , , , , , ,	
-	Examin	ier	4a. Faelity Name (II not institution give street and number) Center 4b. City, Town, or Location of Death	าก	4c. County of Death	timore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 □ M 2 ▼ F	8. Date of Birth (Month, Day, Ye	ar) Cou	nplace (State or Foreign untry)
L	Director		212-84-9162	2/26/196	63 Wash	nington, D.C.
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	8a-fs	Director	MD Baltimore Windsor Mill			1 □Yes 2 No
	with the		10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Cou	
	death ms 23	Funeral	5726 Old Court Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puertol Inference)	ecify Yes or No-	U.S. A	ican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Profest Exaction to the traumatic event, the Profest Exaction Exaction of the profess once.	δ	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes, Specify Cuban, Mexican, Puerto I 1 ☐ Yes, Sive 1 ☐ Yes, Specify: 1 ☐ Yes, Specify: 1 ☐ Yes, Specify:	Hican, etc.)	Black, White	hite
5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the completed)	ng 16t	o. Kind of Business/I	
121	within ene. than '	Jung	Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber	Tn	dustrial l	Plumbing
d 2	al Hygl other vent, I	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name			Tumbing
ylar	Ments Ments arked artic ev	To	Richard Blanchett Pauline	Ann Ells	worth	
Mar	12 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura			
	s 1 and 2 and 2 of Health a ltem 27 is		Sandra B. Osborne, Partner 5726 Old Court Rd., Wi 20a. Method of Disposition (Name of cemetery, crematory or other place)		L1, MD 212 Location - City or T	
altimore,	Pages nent of nt; If I		Parameter 2 Cremation 3 C Removal from State	5/2008 Br	entwood,	MID
alti	epartn epartn nporta ny inju		21. Signature of Fund Service Service 22. Name and Address of Facility	3/2000 DI		timore Avenu
<u> </u>	205 20		Gasch's Funeral Hom			
	D	e 11	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final MASSIVE GASTROINTESTIONAL BLE			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death) Ta. Due to (or as a consequence of): LIVER FAILURE			
		ē				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to lumeridate cause. Enter Underlying Cause (Disease or injury that initiated events			
8760,	flcate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
687	flcate physi s the b	edical	d			
P.O. Box	The law requires that the death certifit ate has been signed by the ettending page 2 should be detached for use as	by Physician/Me	iF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Live birth 2 □ Fetal death 1 □ Ctopic pregnancy 1 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of deli	very Day Year
0	at the de by the tached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			
S, F	res that signed I be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
o o	w requir	ted	HEPATITIS C	1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
Records,	rsician: The law s certificate has b lirector, page 2 sl	Completed	ALCOHOLISM	24a. Was an autopsy performed	24b. Were aut prior to death?	topsy findings available completion of cause of
Vita	lclan: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
ð	Phys er this eral dir	5.7	27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28b. Time of 28c. Time	ne 5 Residenc	e 6 ☐ Other <i>(Spec</i> injury occurred	cify)
<u>o</u>	ath. r: Afte	atior	1 Natural 5 ☐ Pending (Month, Ďay, Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		injury occurred	
Division of Vital	after de after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	n, Day, Year)
	(3)		Gully M. MD D39215	7	111/08	
	Se		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAIL CUNNINGHAM, M.D. 7621 OSLER DRIVE TOWS	ON, MARY	LAND 218	204
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Division or Vital Records, P.O. Box 68760

within 24 hours a completely

> State Registrar

31. Date filed (Month, Day, Year) JUL 1 5 2008

29b. Signature and title of certifier



ado 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

クラマナイ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 1^{Day} 2008 KAREN LEE BOURDEAUX 1:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 219-90-1910 1 □ M 2 🕅 F 46 Yrs. 1962 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show MD 1 ☐ Yes 2 No Director Montgomery Damascus 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 26817 Dix Street 20872 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 'natural", al Hygiene.
d other than "natural
event, it e Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever Daniel A. Ball Elizabeth A. Keyser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Daniel V. Bourdeaux (Husband) 26817 Dix Street Damascus, MD 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) $\mathtt{Ju1v}^{\mathtt{Date}}$ 16, 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 2008 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home of Funeral Service License 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Pulmonary Hypertension disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Acute Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed physician and the burial-transit Interstitial Lung Disease Due to (or as a consequence of): Box 68760, Chronic Obstructive Lung Disease Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypexia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 X Yes 2 □ No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated

State Registrar

31. Date filed (Month, Day, Year) JUL 1 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vinu Ganti 19529 Doctor's Dr.



29b. Signature and title of certifier

29c. License number

D411162

29d. Date signed (Month, Day, Year)

July 11, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Betty Gough Bullard July 2008 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** North Pines Assisted Living Carroll County Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1926 Virginia 577-40-0783 1 □ M 2 1 F 81 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Maryland Carroll County 1X Yes 2 □ No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3943 Brittany Lane 21074 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the "sedical Examiner rust any Injury or other traumatic event, the "sedical Examiner rust once." Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounts payable rep. Construction company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harrington Clark, Jr. Eliza Gough ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Bullard - son 3943 Brittany Lane Hampstead, Maryland 21074 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 15, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Episcopal Cem. 4 ☐ Donation 5 ☐ Other (Specify) Chaptico, Maryland 2008 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 1 www 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNINAN IN FECTION) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day Year 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 🖹 No e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificat To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 032717 12 do (m) WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar	State of Maryla						000	24,	340
	st)						V	3. Time of	Death
Melissa Lenora	ı Hembry Can	non			July 1	I , 200		9:47	P M
4a. Facility Name (If not institution, giv			4b. City, Tow	n, or Location of Dea	th	4c. Cou	nty of Death		
Manor Care of I	argo		Upper	Marlboro		Pri	nce Ge	orgate	
	3 , ,	. last birthday)	If Under 1 Ye	ear If Under 24 Hrs	8. Date of Birth	Year)	9. Birth	place (State or	r Foreign
577-98-2671	LIM 2LXF 40	Yrs.	WOTENS DO	710010	11-23-1	1967			
Usual Residence of Decedent	100.0	iby Town or Lo	ecation					10d Inside Cit	v Limits
			Cation						
	leorge 3 Bo	wie -	1			0.00	/		
	_		10t. Zip Cod] 1	-			
					3				
	Armed Forces?	0.5.	was Decedent If Yes, specify (or Hispanic Origin? (Cuban, Mexican, Pue	to Rican, etc.)	14. E			
	If Yes, Give		1 □ Yes 2 □	No Specify:		Spe	cify: B1a	ıck	
	L	16a Dece	dent's Usual Oc	cupation					
(Specify only highest gra	de completed)	(Give	kind of work do	one during most of wo	orking			,	
Elementary/Secondary (0-12)		В	eautici	.an		Cosme	tology		
17. Father's Name (First, Middle, Last,)			18. Mother's Na					
Vernon Melvin H	embry			Christ	ine Price				
19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Str	reet and Number or R	lura / Route Numbe	r, City or To	wn, State, Zij	p Code)	
Vernon Melvin Hem	bry (Father)	990	6 Bald	Hill Rd.,	Bowie, M	lary1a:	nd 207	21	
20a. Method of Disposition	206.	Place of Disor	sition (Name o						
1 Burial 2 Cremation 3	Removal from State War	y Land B	matory or other aptist	Church	2008	Louis	sa, Vi	rginia	
		2:	2. Name and A	ddress of FacilityTL	.m.a.a.a.a. [1				-
1 2 1	T/ 1 111		117 We	st Street	Louisa	atson Viro	Funer	al Ser	v.,In
23a Part 1 Enter the disease or com							LIIIa Z		9
shock, or heart failure. List only	one cause on each line.			-,	, , , , , , , , , , , , , , , , , , , ,			Onset and E	Death
disease or condition	a							241	EARS
	Due to (or as a conse	equence of):							
Sequentially list conditions,	b. — Due to (or as a conse	equence of).					-		
cause. Enter Underlying Cause (Disease or injury									
that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):	· · · · · · · · · · · · · · · · · · ·		_ , ,	<u> </u>		-	
	_ 0				-				
IF FEMALE:	23c. If yes, outcome of preg	nancy				23d.	Date of deliv	erv	
in the past 12 months?						255	Month	•	r'ear
9 Unknown	9□ Unknown		(/	,					
Part II. Other significant conditions of	contributing to death but not re	esulting in the u	inderlying cause	given in Part I.	23a. Did to	bacco use o	ontribute to	— the cause of d	leath?
					1 🗆 Y	es 2 N	3 ☐ Pro	bably 4 🗀	Jnknown
					242 1400	an 24	Ib. Ware sut	oney findings	available
					autop	sv	prior to co	ompletion of c	ause of
								2 No	
examiner?	Hospital:			Other					
	1 inpatient 2			+ Cartaising				ify)	
1 Matural 5 ☐ Pending		Injury			28d. Describe in	ow injury oc	curred		
3 Suicide 6 Could not b	e Oge Place of Injun. At	home farm			28f Location /6	tropt and N	mher or D	ral Route No.	her
	286. Place of Injury - At	nome, tarm, st cify)	reet, ractory, of	IICB			anu u r of Hüi	ai noule Num	Joi,
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(Check only 2 Medical Example (Check only 2 Medical Example)	minar: On the basis of exami								i)
	and manner stated.		29c Li	cense number		29d. Date si	aned (Month	Day Year	
RA AL T	. T						, ,		
Les ville	new		4	47604		0 =	1101	2008	
30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)			ergen.	~ ~ -	111	
30. Name and address of person who SUBHAN MATHE	completed cause of death (It	em 23a) (Type,	Print) CMELLVI	LE RUAS) 130 WI	E, N	1020	416	
	1- State Registrar 1. Decedent's Name (First, Middle, La. Melissa Lenora 4a. Facility Name (If not institution, giv Manor Care of I 5. Social Security Number 577-98-2671 Usual Residence of Decedent 10a. State 10b. County Maryland Prince G 10e. Street and Number 9906 Bald Hill R 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, Vernon Melvin Hem 19a. Informant's Name/Relationship (Vernon Melvin Hem 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specifications or Common Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 12 Control of Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation (Cause) (Disease or injury that initiated events resulting in death) Last 18 Natural 19 Pending investigation (Cause) (Disease or injury that initiated events resulting in death) Last	1. Decedent's Name (First, Middle, Last) Melissa Lenora Hembry Can 4a. Facility Name (II not institution, give street and number) Manor Care of Largo 5. Social Security Number 6. Sex 1	1. Decedent's Name (First, Middle, Last) Melissa Lenora Hembry Cannon 4a. Facility Name (If not institution, give street and number) Manor Care of Largo 5. Social Security Number 577-98-2671 Usual Residence of Decedent 10a. State 10b. County Maryland 10c. City, Town or Low Aryland 11. Marital Status 1 Never Married 3 Wirdowed 4 Devorced 15. Decedent's Education (Specify only imprest grade completed) Elementary/Secondary (0-12) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Vernon Melvin Hembry 19a. Informant's Name/Relationship (Type, Print) Vernon Melvin Hembry (Father) 19a. Method Disposition 1 Specify only information and provided and pro	1. Decedent's Name (First, Middle, Last) Melissa Lenora Hembry Cannon 4a. Facility Name (Ir not institution, give street and number) Manor Care of Largo S. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last printing) 40. City, Town or Location Bowle 10c. City, Town or Location Bowle 10c. City, Town or Location Bowle 10c. Street and Number 9906 Bald Hill Road 11. Marital Status 1 Never Married Married 3 Windowed 4 Devorced 1. S. Decedert's Escustion (Seecity only highest grade completed) Elementary/Secondary (Cri.2) 1. S. Decedert's Escustion (Seecity only highest grade completed) Elementary/Secondary (Cri.2) 1. Seather's Name (First, Middle, Last) Vernon Melvin Hembry 1. Seather's Name (First, Middle, Last) Vernon Melvin Hembry 1. 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Martal Status 11_Never Maried 12 Was Decedent Fuer in U.S. 11_Never Maried 13. Was Decedent of Hispanic Origin? (in Yes, specify Cubar Mescar, Puer in Usar or Dates) 11_Never Maried 12 Was Decedent Fuer in U.S. 11 Wes, specify Cubar Mescar, Puer in Usar or Dates: 12 Was Decedent Studion (Specify only ingress or de completed) 13. Was Decedent Studion (Specify only ingress or de completed) 14 Wes, specify Cubar Mescar, Puer in Usar or Dates: 15 Decedent's Usual Cocupation (Specify only ingress or de completed) 16 Decedent's Usual Cocupation 16 Decedent's Usual Cocupation 17. Father's Name (First, Middle, Last) Vernon Mel'vin Hembry 19a. Informant's Name-Relationship (Type, Print) Vernon Mel'vin Hembry (Father) 19b. Mailing Address (Street and Number or Pageo) 10c. Street or December of December or Pageo) 10c. Street or Dec	1. Descent's Name (First, Modis, Last) Mellissa Lenora Hembry Cannon Mellissa Lenora Hembry Cannon 4. Facility Name (First, Modis, Last) Manor Care of Large Social Security Name (First, Modis, Last) Manor Care of Large 1. Descent's Name (First, Modis, Last) Manor Care of Large 1. Descent's Name (First, Modis, Last) Manor Care of Large 1. Descent's Name (First, Modis, Last) Manual Residence of Descentin 1. Descent Name (First, Modis, Last) Maryland Prince George's Bowle 1. Descent Name (First, Modis, Last) 1. Descent Name (First, Modis, Last) Vernon Melvin Hembry 1. Descent Name (First, Modis, Last) Vernon Melvin Hembry (Father) 1. Special Security (Specify) 1. Special Security (Specify) 1. Special Security (Specify) 1. Was Descent Name (First, Modis, Last) Vernon Melvin Hembry (Father) 1. Special Security (Specify) 1. Special Secu	1. Descentive Name (First, Medice, Last) Me 1. Sea Lemora Hembry Cannon Manor Care of Largo S. Secul Security Number Sea Sea Sea and number Descentification of the County of Lemon 1 Descentification of the County of Lemon 1 Descentification of Largo Descentification Descentific	1. Descent Name (First Motion, Least) Net Itses Lenota Hembry Cannon 4. Facility Name (Frost Motion, per street and number) Net Itses Lenota Hembry Cannon 4. Facility Name (Frost Motion, per street and number) Namor Care of Largo 4. Facility Name (Frost Amotion, per street and number) Namor Care of Largo 4. City Town of Location of Death Namor Care of Largo 4. Duper Maribory 5. Social Search Number 10. County Death Perince Care 10. County Death Perince Care 10. County Number 10. County Death Perince Care 10. County Death Number 10. County Death Perince Care Production Pro	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Day Campbell George B TULY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Plata harle ivista enter ica If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 06/25/ Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days 1 X M 2 □ F 217-26-1799 84 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 XYes 2 No Charlotte Hall Charles Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20622 14563 Oaks Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: Black 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farming 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Campbell Francis Chisley Nick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14563 Oaks_Rd. Charlotte Hall,Maryland20622 Mary Campbell/ Wife 20c. Location - City or Town, State Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 07/17/08 Charlotte Hall, 4 □ Donation 5 □ Other (Specify) St. Marys 22. Name and Address of Facility 21. Signature of Funeral Service License Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nknown 2 No 3 Probably 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 3□ DOA 1 ☐ Yes 2 ☐ ER/Outpatient 28a Date of Injury (Month, Day Year) 27. Manper of teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner the death certificate be executed attending physician and for use as the burial-tran Box 68760. P.O. signed by the Division or Vital Records, need cate has page 2 s certificate or Attending Physiclan:

Physician/Medical Examiner

29a. Certifier

29b. Signature and title of certifier

After this Funeral Director: A etely filled in by the fu hours after death

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

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ant of Health and Mental Hit: If Item 27 Is marked oth y or other traumatic even

permit. Page Department of Important: If any Injury or once.

Physician /Medical

Pages 1 and 2

Directo

Funeral

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other traumatic event, the Medical Examiner must be notified

should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Completed Be ျှ Certification:

within 24

24

State Registrar

Medical

(Check only one)

a

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO Krishan 31. Date filed (Month, Day, Year)

> JUL 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July ^{Day} 2008 Year **Physician** 10, Laura L. Cunningham 2:34 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Months Hours 1 □ M 2 🛚 F 177-24-7624 79 Sept. 30, 1928 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event the Marian. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 □Yes 2XINo Charles Waldorf Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4045 Forest Lane 20601 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify.White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Pierce William G. Satzler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4045 Forest Lane, Waldorf, Md. Kimberly C. Sowell Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) July 15, 2008
Southern Memorial Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 ase, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so List only one cause on each line. amer the dise snock, or heart fail. Immediate Cause (Fin disease or condition resulting in de-Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart to **Physician** Ironto-tanetal acute /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown denimo Dabe te heasit Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an chromi page 2: autopsy perform &ZNO Physiclan: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 N Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Apatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After . Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 07-12-2008 D63183 V-Konnan MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Rd., Clinton, Md. 20735 Vijay Kannan, M.D., 31. Date filed (Month, Day, Year) State 2008 JUL 15 Registrar

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 8 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Year JACquelin ANNES 12:26 AM 06 200X 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death AMNO ARUNDE Annapolis Arradel Menual Center If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) July 29, Birthplece (State or Foreign Country) 1□ M 2√√F Deys Hours Yrs. 212-54-9851 60 1947 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1520 Enyart Way #202 21409 United States 12. Was Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes ŽŒNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Administrative Assistant County Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John E. Donald Luella Rice 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B. Cogar / Husband 1520 Enyart Way #202 Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/8/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 21 No 3 Probably 4 Unknown 15UMmla 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

/Medical

Be Completed by Funeral Director

10a. State

by Physician/Medical Examiner Be Completed Certification: To in by the funerel within 24 hours aftar death.

To the Funeral Director: All completely filled in by the fu

Hospital or Attending Physician: The law raquiras that the death certificata be axecuted

Director: After this

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Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

25. Was case referred to medical examiner? 1 🗌 Yes 20

26. Place of Death (Check only Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Natural 2 Accident 5 Pending investigetion 6 Could not be determined 3 Suicide 4 Homicide

1 Yes 2 No

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ZLINO

(Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

NEL SUrgery Atterding (GA) 034712

29d. Date signed (Month, Day, Year) 7/7/2008

e of death (Item 23e) (Type, Print) Name end eddress of person who ampleted

CRC 3-5941 NOT 9000 Rockwills Pube Bethesda MO 20892

Registrar

Medicai

31. Date filed (Month, Day, Year) 1 4 2008 legistrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** Terrill 07 S. Carmack 08 05,49M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min Months 1 **X** M 2 □ F 189-44-2516 52 Director 2/15/1956 Pennsylvania Usual Residence of Decedent Maryland 10a. State 10d. Inside City Limits 10h County 10c. City. Town or Location ns 23a or 28a-f sh must be rotified 1 XYes 2 No Director Texas El Paso El Paso the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11109 Cutty Sark 79936 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Date: 974-77 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 7 is marked other than "natural", or iten traumatic event, the Medical Exp. citrer 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer U.S. Government and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2/15/56 Merrill V. Carmack Caroline McCleary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn M. Carmack/son 519 hand St., Chambersburg, PA 17201 permit. Pages 1 an Department of Health Important: If item 27 any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other pla Thomas L. Geisel 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 7/18/08 Chambersburg, PA 21. Signature of Funeral Service Len 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PEPTIC WECER disease or condition resulting in death) HENDORRHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Yea Day 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) f⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō thin 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the To the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who complete

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DOROTH

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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203 SNOW STI

cause of death (Item 23a) (Type, Print)

MORTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25,23a per me, 2882, 08/02/08dbb, 28b, f. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wayne Month Carl Christie 10:45 p^M July 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5098 Swordfish Drive Wicomico Eden If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 □ F 54 Director 188-44-7088 9/14/1953 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f show event, the Wedical Examination ust be notified at 1 ☐ Yes 2 X No Director Wicomico Maryland Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5098 Swordfish Drive 21822 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No If Yes, Give AirForce Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify white 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Wal Mart floor maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Christie ည unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5098 Swordfish Dr., Eden, MD 21822 Norma Jean Bew/significant other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 7/10/08 Salisbury, MD injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Kell R 23a. Part 1. Enter the disease, or complic from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RAUMATIC **Physician** MIRAN! /Medical Due to (or as a consequence of): Examiner VEHICLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner NTOXICATION sician and burlal-trans Due to (or as a consequence of) physician at the burlas 68760 Physician/Medical The law requires that the death certificate use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) o been signed by the should be detached if 1 ☐Yes 2 ☐No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ŕecords, Completed by NATORY NESTI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No 1 ☐ Yes 2 MNo 1 □ Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific zempletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1X Yes 2-2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Pay, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 □ Natural 5 Pending investigation MCC1110UT MONEM 4:57p 19 108 1 ☐Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Boute Number, City or Town, State Cooper Rd. near Harcum Wharf Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 10038662 0 MYSIUM IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONTHATIONT CLIMIC AFFIRI Veteraus egistrar's Signature 31. Date filed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2008 July 12, **Physician** Edna Eleanor Chaney 1:36 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomerv 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2X F 83 Director 579**-**26-1014 April 15. 1925 Wash. Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modeal Examina must be notified at Director 1 ☐ Yes 2√2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12509 Marie Court 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 Bank permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Anderson Rebecca Anna. Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Chaney (son) 12509 Marie Court Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithville UMC Cem. Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goif 8125 Southern Maryland Blvd Owings. MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronery Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hypertension Due to (or as a consequence of): burial physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 □ Yes 2 XINo 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital

the Maryland

death v

within 72 hours after

Baltimore, Maryland 21215-0036

signed by the a certificate this After Hospital or Attending n 24 hours after death.

e Funeral Director: At letely filled in by the fur completely within 2

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1500 Forest Glen Road Murphy,

Year)

15

2008

of cert

Registrar's Signature

Silver Spring, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D41624

29d. Date signed (Month. Day, Year)

20910

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** July 10, 2008 4:50 A Christian Raymond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 607 Elm Avenue Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Director 292-30-4735 70 25, 1937 Ohio Nov. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dkal Examiner must be notified at No Yes 2 No Director Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 607 Elm Avenue 20912 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2X Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 K No Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed withii Hygiene. College (1-4or 5+) 4 years Postal Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I William Christian Eva Allen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie M. Christian - Wife 607 Elm Avenue Takoma Park, MD 20912 Item 27 i injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any Injury or ot tx Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery July 15, 2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) or ature of Funeral Survice L 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate
Interval Between Immediate Cause (Final 7 Months Metastatic Cancer to Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urethral Cancer 7 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: certificate be executed burial-transi Exami resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No The law 24a. Was an page 2 s has certificate 1∐ Yes 2€ No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760. P.O. or Vital Records, Division

Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,)
JUL 1 5 2008

29a. Certifier

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick A. Crodd, M.D. 6510 Kenilworth Ave #2800 Riverdale, MD 20737

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

DA1728

29d. Date signed (Month, Day, Year) July 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** Ba Van Cao 13, July 9:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ F Months Days Hours 218-31-4882 Director Dec. 31, 1926 Vietnam Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or Items 23a or 28a-f shorevent, the Medical Examinar must be notified at Director Maryland Montgomery Silver Spring 1 ☐ Yes 2 TrNo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 3346 Claridge Court 20902 Vietnam Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 Tes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 21≦No Specify: ρ Specify: 3 ☐ Widowed 4 ☐ Divorced As<u>ian</u> Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 <u>Farmer</u> permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If Item 27 is marked other i any Injury or other traumatic event, III Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Nhieu Van Cao Tien Thi Pham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cuc Thi Truong/Wife 3346 Claridge Court, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State July 16 1 ☐ By (a) 2 XX remation 3 ☐ Removal from State Metropolitan Crematory 4 □ KonAtion 5 Other (Specify) 2008 Alexandria, Virginia gnat 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer
Due to (r as a consequence of): /Medical Examiner Metastases to Brain, Liver, Bone 6 mos. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of): burlal-Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρď in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) o the detached 9 Unknown 9 Unknown ٣. ρ signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s was a... autopsy performed? Yes 2 2 No certificate of Vital 1 ☐Yes 2 No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pont 24 hours after death.

He Funeral Director: After the pletely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Supunich D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, MD Holy Cross Hospital 1500 Forest Glen Road, Silver Spring, MD 209 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 15 2008 Registrar

08-05142 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Amend Items 10e and 11 Cper spouse mf 883 9/4/ Paul E. Clark 1- For State Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 4, 2008 1515 hrs Medical Examiner PAUL Ε. CLARK 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Fort Washington Hospital Fort Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignNORTH 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Director 579-56-4439 SEPT 9 1942 M X 65 Court AROLINA 2 Usual Residence of Decedent 10d. Inside City Limits 'n 10a, State 10c. City. Town or Location 1 X Yes 2 No 28a-f show rant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at once. PRINCE GEORGE'S MD UPPER MARLBORO Director 10g, Citizen of What Country 2915 Brinkley Road, Apt 202, Temple 5110-WEST-MAPLE SHADE LANE Hills MD 20772 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XX Married Yes BLACK 4 X Divorced 1 Yes 2X No specify: 3 Widowed Yes. Give Year Specify: 2 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl 2 yrs PRIVATE MANAGER 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLIE CLARK MARGARET DUBLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVON C. CLARK/SON 2601 PRESTONWOOD DRIVE PLANO, TEXAS 75093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: 7/12/2008 LAUREL, MARYLAND NATIONAL CEMETERY Donation 5 Other Specify: 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Bilateral Pulmonary Thromboemboli Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical UNPENDED ed by the attending physician detached for use as the burial **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed ector, page 2 should be deta ੬ 1 Yes 2 No 3 Probably 4 🗸 Unknown Completed Records, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 ✓ Yes No 26.Place of Death (Check only one) the funeral director, 25. Was case referred to medical Division of Vital Be examiner? Other: Inpatient 2 Y ER/Outpatient 3 Nursing Home 5 Residence 6 After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Hospital or Attending Physician: To the Funeral Director: completely filled in by the

St

Medical

JUL 1 5 2008 State Registra

29b. Signatule and title of sertifie

Laron Locke MD.

and manner stated

Assistant Medical Examiner

Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 6, 2008

Phy: /M Exa

Fune Direct

		For	State of Marylan				/lental Hy	giene	2008	243	250
		State Registrar		Cei	rtificate of l	Death		Reg. No.	2000	C 19 C	00
sicia	an	Decedent's Name (First, Middle, La	ist)				2. Date of De Month	ath Day	Year	3. Time of I	Death
edic		Leo Daneri							2008	1:05	<u>р</u> М
min	er	4a. Facility Name (If not institution, give	•			Location of Death		4c.	County of Death	_	
·		11618 Riversho 5. Social Security Number 6.5		last birthdav)	D If Under 1 Year	unkirk If Under 24 Hrs.	8. Date of Bir	th	Calver 9. Birth	t place (State or	Foreian
ral tor			1XM 2□F 90	Yrs.	Months Days	Hours Min.	(Month, Da		Cot	DC	
		Usual Residence of Decedent					, , , , ,				
	-	10a. State 10b. County	10c. City	y, Town or Lo						10d. Inside City 1 ☑ Yes	
	Director	MD Calv	vert		_	unkirk		10 014		A.	
		10e. Street and Number			10f. Zip Code			rog. Citi	zen of What Cou	intry?	
	Funeral	11618 Riversho	ore Drive 12. Was Decedent Ever in U.	S. 13.		0754 ispanic Origin? (Sr	pecify Yes or No)-	USA 14. Race - Amer	ican Indian,	
	필	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cuba		o Rićan, etc.)		Black, White	, etc.	
	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🔀 No	Specify:			Specify: W]	hite	
	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	durina most of worl	kina	16b. Ki	nd of Business/I	ndustry	
	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)			Printi	0.07	
	S	17. Father's Name (First, Middle, Lasi	t)		Print	18. Mother's Nam	ne (First Middle			ilg	
	Be c	Frank Daneri	,					_	Carnamey		
	ဥ	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	Theres			or Town, State, Z	ip Code)	
		Gerri Gable/Da	aughter	3909	Lakesi	de Ct.,	Dunki	rk.	MD 20	754	
		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place	i	Date		ocation - City or		
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🔀 Other (Speci	_Hemoval from State	-	rial Gd	i i	7/08	Dunl	kirk, N	I D	
once.		21. Signature of Funeral Service Lice			2. Name and Addre				od F.H.		•
Б		10.0	on	F	O Box 4	30, Dun	kirk,	MD	20754		
д. Ф		23a. Part1. Enter the disease, or con shock, or heart failure. List only	oplications that caused the death one cause on each line.	h. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Bety	veen
an		Immediate Cause (Final disease or condition	Bladder	CO	ancer				ı İ	Onset and D	S
al er		resulting in death)	Due to (or as a conseq	uence of):)	
200	_	Sequentially list conditions,	b Due to (or as a conseq	uence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dende oi).							
	Exal	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):							
	dical		d								
	ledi										
	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		∃Ectopic pregnancy	,			23d. Date of deli	,	
	sicia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at time of d		Other (specify)	<u> </u>			Month	Day Y	'ear
	Completed by Physician/Me	9 Unknown		ulting in the	nded ting on the site	es is Best I	220 Did	tohoooo	use contribute to	the course of d	n ath ?
	by	Part II. Other significant conditions	contributing to death but not les	ulung in the u	ndenying cause giv	en in Part I.		Yes 2		obably 4 ∏U	
	eted								_		
	mple						24a. Was	psv	24b. Were au prior to death?	topsy findings a completion of ca	available luse of
	ပိ	05.146	T					ormed? 2 No	1 ☐ Yes	2□No	
) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outration	ot 3DDOA Oth	26. Place of Dea	1				
	<u>۱</u>	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	IL OF BOW	4 Li Nuising II	ome 5 Res 28d. Describe		6 ☐Other (Specify occurred	cify)	
	ition	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury		k? Yes 2∐No					
	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location		nd Number or Ru	ıral Route Num	ber,
	Cert		building, etc. (Opecin	<i>y</i> /			Ony of re	mii, Olaic	5)		
	Medical Certification:	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kno iminer: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s e, date an	s) and manner as d place, and due	stated. to the cause(s)
	M	29b. Signature and title of certifier			29c. Licens				ate signed (Mont		O
		Jarol Hx	to MD		0005	9061		JU	ly 14 M	1 200	2
		30. Name and address of person who			,	_	'	_			
		Arati Patel, M	.D. 110 Hosp	ita1	Road #2	12, Pr.	Frede	ric	k, MD 2	20678	

Registrar
DHMH 17 Rev 1/2001

Ormen & Sparle

1 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** JULY 6, 2:44 THEODORE W. DORSEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1515 Harding Lane MONTGOMERY Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F Months 214-32-7760 Yrs. Director 73 Aug. 16, 1934 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examirer must be notified at Director Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Harding Lane 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: à Specify: Black 3 Widowed 4 Divorced 1956 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) 12th College (1-4or 5+) Public Schools Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garfield Dorsey မှ Janie Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 1515 Harding Ln Silver Spring, MD 20905 Evelyn Dorsey- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal fr Veterans Cem 7/16/08 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Lig-22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical the ' IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) the 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 201No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P(0. Division of Vital Records, To the Hospital or Attendi
within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi Medical

> State Registrar

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUL

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RECK

ER

32/Registrar's Signature

10

moDME

MO DOME

29c. License number

2101

00428

29d, Date signed (Month, Day, Year)

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	of Maryland / Depa			ene g. No. 2008	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Connie McGowan Ewin			2. Date of Death Month July 10), 2008 Year	3. Time of Death 8:45 P M
1	Examir	ner	4a. Facility Name (If not institution, give street and r Homewood at Crumland Fa	,	4b. City, Town, or Loca Freder	ick	4c. County of Death Frederi	.ck
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday) 66 Yrs.		Juder 24 Hrs. 8. Date of Birth (Month, Day, Aug. 23,	Year) 1941 Mar	place (State or Foreign Intry) yland
	Maryland	ior	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or Lo Frede				10d. Inside City Limits 1 ☐ Yes 2 X No
	a or 28a-	Direct	10e. Street and Number 6870 Buckthorn Court		10f. Zip Code	21703	og. Citizen of What Cou Jnited Stat	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any njury or other traumatic event. I'm Modical Examinar must be notified at ance.	by Funeral Director	Armed	s 2⊠No Give		nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Amer Black, White	ican Indian,
Maryland 21215-0036	within 72 ho sne. Ihen "natur ie Medical	Completed	15. Decedent's Education (Specify only highest grade complete) Elementary/Secondary (0-12) 1 2	(Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	16b. Kind of Business/li	
land 2	uld be filed Mental Hygie irked other itic event. It	To Be Co	17. Father's Name (First, Middle, Last) Woodrow Wilson McGowan	Loa	n Officer	Mother's Name (First, Middle, M Juanita Bowman		18
, Man	and 2 sho eith and 1 127 ie ma er traume		19a. Informant's Name/Relationship (Type, Print) Debbie Facine / Daught		-	Number or Rural Route Number, Dr., Adamstown		
Baltimore,	Pages 1 and of He out: If Item		20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)		osition <i>(Name of</i> 1402 (<i>Yet</i>her place) 1 Gardens	July 14,	20c. Location - City or 1 Frederick,	
Balti	permit. Departri		21. Signature Licensee	22 R. 9	2. Name and Address of esthaven Fu 501 Catocti	neral Services n Mtn. Hwy. Fre	, Skkot Cod ederick, MI	ly P.A. 0 21701
	Physician /Medical		23a. Part1. Enter the disease) or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) a	t caused the death. Do not ent				Approximate Interval Between Onset and Death
,092	re be executed ysician and e burial-transit	lical Examiner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of): o (or as a consequence of): o (or as a consequence of):	ienoma)			6mos
	that the death certificate I ed by the attending physi detached for use as the b	Physician/Medi	in the past 12 Months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	sign 3 be	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in	Part I. 23e. Did tob	es 2 No 3 Pro	
		Completed				24a. Was an autops perform	y prior to d	topsy findings available completion of cause of 20 No
on of Vital	To the Hospitel or Attending Physician: within 24 hours eiter death. To the Funeral Director: Affect this certification in the funeral director, completely filled in by the funeral director.	tlon; To Be	27. Manner of Jeath 1 Natural 5 Pending (M	Inpatient 2 ER/Outpatier te of Injury 28b. Time o	nt 3 DOA Other:			cify)
Division	el or Atten setter deat i Director: d in by the	Certification;	3 Suicide 6 Could not be	ce of Injury - At home, farm, str Iding, etc. (Specify)			reet and Number or Ru ı, State)	ral Route Number,
	he Hospitt in 24 hours he Funera pletely fille	Medical C	(Check only 22 Medical Examiner: On the	he best of my knowledge, doat basis of examination and/or in anner stated.	h decemed at the time, divestigation, in my opinion	ate and place, and due to the et n, death occurred at the time, do	luse(s) and manner as ate and place, and due	stated. to the cause(s)
)	To t To tl	Σ	29b. Signature and title greentiles	un	29c. License nur	mber 3971	9d. Date/Signed (<i>Montl</i>	h, Day, Year)
	\ <u>\</u>		30. Name and address of person who impleted ca Robert L. Kaufmann, M.I			derick, MD 2170)1	
	Sta Registi		31. Date filed (Month, Day, Year). 4. 2008 32	Registrar's Signature	parks			

DHMH 17 Rev 1/2001

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20101/1 2000

Known to physicians as: Connie Ewin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Malinda Ella Ennis July 12, 2008 6:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 530 Druid Hill Wicomico Salisbury 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 1 F 214-10-109 98 Director 10/18/1909 Virginia Usual Residence of Decedent init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinant countries to notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 Druid Hill 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No ģ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel James Griffith Adella Florence Marshall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Justice/friend altimore, 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or 7/17/08 Salisbury, MD Parsons Cemetery 21. Signature of Funeral Service Acensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or mjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burlal-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No certificate | 1 ☐ Yes 2 No : After this certification by funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 2 ☐ Accident 5 Pending thin 24 hours after by the Funeral Director: After the funeral by the funeral by the funeral filled in by the funeral filled in by the funeral functions and functions are functions. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

NATESAN

JUL 17

Division of Vital Records,

strar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 23 AM tenre amer harles 2008 /Medical 10 July 4a. Facility Name (If not institution, give street and number) 4o. County of Death 4b. City, Town, or Location of Death Examiner CROSS Montgomery 9. Birthplace (Statt or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year **Funeral** 1 1 M 2 □ F Months Days Hours Min. 217-14-8019 Usual Residence of Decedent 801 Director Maryland 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show 1 res 2 No Funeral Director Janassas 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? US ey Manor Drive 20 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Exaction 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Haricultura 6 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ SSac aura amer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Sudley Manor DR. Manassas Vai amer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 D Buria! 2 ☐ Cremation 3 ☐ Removal from State 7/15/08 4 Donation 5 Dother (Specify) Spring Grove Cemetery! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Fureral Home, Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD. 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Large Intracranial Hemorrhage 25 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Stroke and Ibdie Due to (or as a consequence of): attending physiciar Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 HInknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð Change in mental status, hypertension, cardiac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed myopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe B 2 No 1 ☐Yes 2 No Vital Physician: 25. Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this of 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manper of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a ical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 065953 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Adaku Chimtua Onukogu,

31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Holy Cross Hospital, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24356 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 10:45 aM 2008 Ann Misler Folus July 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 10401 Grosvenor Place, #1121 Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕱 F Director 579-12-0252 87 August 16, 1920 District of Columbia Usual Residence of Decedent וו Should be filed within 72 hours after death with the Maryland h and Mental Hygiene. r is marked other than "natural".or items אפא מיי אפאי אראייי 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location , or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2 🛣 No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10401 Grosvenor Place, #1121 20852 II.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Misler Sarah Blecman မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health ar permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr 27 Ellen Futterman - Daughter 8000 Cypress Grove Lane, Cabin John, Maryland 20818 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 🗷 Rg 4 Doration 5 ☐ Other (Specify) King David Memorial Gardens 07/15/2008 Falls Church, Virginia 22. Name and Address of Facility ure of Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re.) ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 🗆 No 1 □ Yes 2 🗷 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 x No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ANatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 negistrar's Signature

Ava A. Kaufman, M.D.,

15

31. Date filed (Month, Day, Year)

JUL

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M.P.H., 8218 Wisconsin Avenue, Suite 103, Bethesda, Maryland 20814

July 14, 2008

Physicia /Medic Examin

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liutry or other traumatic event, If we Modical Exeminer must be notified at agree. Once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Registrar	State of Maryla		epartment of I Certificate of			g. No. 2111	18 21.25
. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
Ferdi	nand Albert	Grove	e, Jr.		July 11,	Day Yea 2008	6.15 PM
a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	3 .	4c. County of D	eath
VA Mary and HE21Hr. Social Security Number 6. Se	Care Suste	ns last hirth	(ETTY Tol	If Under 24 Hrs.	8. Date of Birth	CECIL	Birthplace (State or Foreign
	M 2□F 8		rs. Months Days	Hours Min.	(Month, Day, Dec. 8,	Vear)	Country) Maryland
0a. State 10b. County	10c.	City, Town	or Location				10d. Inside City Limits
Maryland Cecil			Port De	eposit			1 ☐ Yes 2 🔀 No
0e. Street and Number	7		10f. Zip Code	224	10	g. Citizen of What	
111 Craigtown Ro	12. Was Decedent Ever in	IIS		904	ecify Ves or No-	U.S.	Merican Indian,
1X Never Married 2 Married	Armed Forces? 1√ Yes 2 □ No		13. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 🖾 No	an, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
3 Widowed 4 Divorced	Year or Dates: 194					Specify:	White
15. Decedent's Edu (Specify only highest grad	de completed)	(Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing 1	6b. Kind of Busine berdeen]	ss/Industry Proving Groun
Elementary/Secondary (0-12) Eight Years	College (1-4or 5+)			orer	A	berdeen,	Maryland
7. Father's Name (First, Middle, Last)		1		18. Mother's Name	e (First, Middle, M	aiden Surname)	
Ferdinand	d Albert Grov	re, Sr	•		Ella E.	Smith	
9a. Informant's Name/Relationship (7)		T	Mailing Address (Street				
Emily Grove (sist			O Craigtown			oc. Location - City	
1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	nemoval from State		Disposition (Name of crematory or other pla iry Cemeter				sit, Maryland
Signifure of Funeral Service Licens Sa. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de		22. Name and Address Lee A. Pat Perryville of enter the mode of dy	terson & , Marylan	d 21903	-0766	Approximate Interval Between
dequentially list conditions, etc., leading to time under ause. Enter Underlying ause. Cliescase or injury nat initiated events esulting in death) Last	Due to (or as a cons Due to (or as a cons C. Due to (or as a cons d.	equenes of): 				
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	у		23d. Date of Month	delivery Day Year
art II. Other significant conditions co	ntributing to death but not i	esulting in t	the underlying cause giv	en in Part I.			e to the cause of death? Probably 4 🔀 Unknown
					24a. Was an autopsy perform 1 □ Yes 2	ed? prior	autopsy findings available to completion of cause of 1? 'es 2 \Bo
Was case referred to medical	Hospital:	ПЕРІО	patient 3 DOA Oth	or:	h (Check only one		
examiner?	I M Inpatient 2	28b. Tir	me of 28c. Inju	ry at k?	28d. Describe how	nce 6 Other (Something of the following	ipecity)
examiner? 1 ☐ Yes 2 ☑ No 7. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year,	inj	M I 1 □	Yes 2 INn I			
examiner? 1 ☐ Yes 2 ☑ No 7. Manner of Death	28a. Date of Injury (Month, Day, Year, 28e. Place of Injury - Al building, etc. (Spe	home, farn		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 9a. Certiffier 1 Certifying Phy 1 Certifying Phy	(Month, Day, Year,	home, farn	n, street, factory, office	me, date and place.	City or Town,	State)	r as stated
1	28e. Place of Injury - Albuilding, etc. (Spesician: To the best of my liner: On the basis of exam	home, farn	n, street, factory, office	me, date and place, ppinion, death occur	City or Town, and due to the ca red at the time, da	State)	r as stated. due to the cause(s)
examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 9a. Certifier (Check only one)	28e. Place of Injury - Albuilding, etc. (Spe sician: To the best of my Inner: On the basis of exam and manner stated.	home, farm	death occurred at the toler investigation, in my construction.	me, date and place, ppinion, death occur	City or Town, and due to the ca red at the time, da	State) use(s) and manne te and place, and d Date signed (M	r as stated. due to the cause(s)

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State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 24359 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JT Glovier July 9, 6:10 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 446 Fairhaven Road Tracys Landing Anne Arundel County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**∑**M 2□F Yrs. Director 400-34-9603 77 May 19. 1931 Kentucky Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h Counts 10c. City. Town or Location items 23a or 28e-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Co. Tracys Landing 10e. Street and Number 10g. Citizen of What Country? 446 Fairhaven Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or items 23e eny injury or other treumetic event, the Mentales. 20779 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Agned Forces?

1 2 Yes 2 No 195

If Yes, Give Year or Dates: 195 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1950 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 □ Divorced 1955 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) NSA/Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Director of Cryptography +2 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Glovier Euna Lee Hughes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Glovier (Son) 446 Fairbayen Road, Tracys Landing, MD 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July II. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory 2008 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fund 9 Michael 8125 Southern Maryland Blvd., Owings, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ance **Physician** 3 years disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expenses) Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes After this certification, j Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28d. D scribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of De it 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A investigation filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1752830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #900, Ampplismp 2140 Werner, 900 Bestoath 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 2008 Registrar Dans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Patricia Ann Grossnickle 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown

17 Year | If Under 24 Hrs. | 8. Date of Birth

(Month, Day, Year) Washington County Hospital Washington

9. Birthplace (State or Foreign Country) If Under 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XXF Months Yrs Director 68 Feb.24,1940 Maryland 577-58-5793 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Moderl Expurier is ust be rectified at once. 10a State 10c. City, Town or Location 1**X** es 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 1428 Potomac Ave. 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes XXNo Specify \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Housewife</u> Home Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Park O. Beaver, Sr Thelma P. Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Grossnickle-Husband 1428 Potomac Avenue Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Greenlawn Mem. Park July 17,2008 | Williamsport, Maryland of Funeral Service Licensee Osborne Artineración Home, P.A. 425 S. Conococheague St. Williamsport, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Tear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence on sician and burial-trans resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 1 Yes 2 No 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5H-6

P.O. Box 68760.

Division of Vital Records.

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21740

			For State Registrar	State	of Mary	and / Depa	artment <i>rtificate</i>				lental Hyg R	iene _{eg. No} 2 (008	24361
		*	1. Decedent's Name (First, Midd	fle, Last)							2. Date of Dear		Year	3. Time of Death
ķ	Physici /Medio			Leonora Le	etitia G	Lasgow					July	12	2008	6:11 p M
2	Examir		4a. Facility Name (If not institution	on, give street and	nu m ber)		4b. City, To	own, or	Location	of Death		4c. Cou	nty of Death	
9			6800 New Hamps	hire Avenue	2			Ta	akoma	Park			Mont	gomery
	Funeral Director		5. Social Security Number 579-04-6056	6. Sex 1 □ M 2 3 F		yrs. last birthday) 72 Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) April 12.	Year)	Cou	place (State or Foreign ntry) Guyana
	ס		Usual Residence of Decedent											
	ylan		10a. State 10b. Count	y	100	c. City, Town or Lo	ocation						1	10d, Inside City Limits
	Mar a-f sl	ż	Maryland M	ontgomery					Takom	a Par	k			1 X Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip C	Code			1	0g. Citizen	of What Cou	ntry?
	h wit		6800 New Hamps	hire Avenue	<u>.</u>			:	20912				U.	S.A.
	deat ms	Funeral	11. Marital Status	12. Was D	ecedent Ever Forces?	in U.S. 13.	Was Decede	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or No-		Race - Ameri Black, White,	
9	after or Ite	正	1 Never Married 2 ■ Ma		s 2 🗶 No		1 ☐ Yes 2		Specify:		r iloari, cto.			etc.
ဗ္ဗ	ral",	l by	3 ☐ Widowed 4 ☐ Divorce	d Year o	r Dates:		10163 2	140	ореспу.			Spe	ecify:	Black
2-0	72 h	Completed		nt's Education est grade complete	ed)		dent's Usual kind of work			st of work	ing I	16b. Kind o	f Business/Ir	dustry
2	ithin ne. nan "	현	Elementary/Secondary (0-12)		e (1-4or 5+)	`life.	DO NOT use	e retired)					
2	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	ပ္ပ	12				Se	ecre					Acade	mic
ב	be fill ntal H id oth even	Be	17. Father's Name (First, Middle	e, Last)					18. Moth	ers Name	(First, Middle,		,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	မ		fred Green								Lickori		
Jai	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relation	ship (Type. Print)		19b. Maili	ng Address (Street a	and Numb	er or Rur	al Route Numbe	r, City or To	wn, State, Zi	o Code)
	s 1 and 2 f Health item 27 l		Allison C. Mar	ks - Daught		1495 Ob. Place of Dispo			Circl		lver Spri	<u> </u>	yland 2 on - City or T	
0			20a. Method of Disposition 1 Buria 2 □ Cremation	3 □Removal fro		cemetery, cre	matory or oth	her plac	e)	,	Jale	200. Localio	on - City or 1	own, State
Ē	: Pa tmen tant: jury		4 □ Dovation 5 □ Other (Specify Specify		Gate of H					9/2008	Silver	Spring	, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or off e.		21. Signature of Funeral Service	e Licensee		H	2. Name and i nes-Ri i	nald	i Fune	ral H	ome, Inc.			
			Tracy.	m. / 8	ac .				•				ng, Mar	yland 20904
			shock, or heart failure. Lis	or complications the st only one cause of	at caused the n each line.	death. Do not en	ter the mode	of dyin	g, such as	cardiac	or respiratory an	est,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	_a.]	Breast C	ancer with	Metast	asis						
1	/Medical Examiner		resulting in death)	Due	to (or as a coi	nsequence of):								
	LAdiiiiiei		Sequentially list conditions,	b										
3.5	p #	Examiner	Sequentially list conditions, if any, leading to immediate	Due	to (or as a coi	nsequence of):								
	and -tran	каш	Cause (Disease or injury that initiated events resulting in death) Last	C	to for as a sou	nsequence of):								
90	ficate be executed physician and is the burial-transit	E	,	Due	to for as a cor	isequence oi).								
8760	cate o	dical		d										
×	death certifi attending p I for use as	0	IF FEMALE:	220 If you	outcome pf pr	o anonav			-	77.				
Box	atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Liv	re birth 2 🗌	Fetal death 3	⊒Ectopic pre		,			23d.	Date of delive	rery Day Year
o.	at the de by the a stached i	/sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown		egnant at time iknown	or death 51	Other (spe	ecity)						
1	The law requires that the death certificte has been signed by the attending I age 2 should be detached for use as		Part II. Other significant condit	tions contributing to	o death but no	t resulting in the L	ınderivina caı	use div	en in Part	1.	23e. Did to	bacco use	contribute to	the cause of death?
Records ,	w requires that been signed to should be deta	by		g ·				3						bably 4 Unknown
Ö	requ	Completed												
ě	e law has t	npfe									24a. Was a autop perfor	sv l	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
	(6 7	Co										2 No	1 ☐ Yes	2□ No
Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medic examiner?					Oth		e of Deat	h <i>(Check only oi</i>	10)		
	this ald	ပ္	1 Yes 2 No			2 ER/Outpatie			4 🗆 14	ursing Ho	me 5 🗷 Resid			ify)
<u></u>	ng ifter	on:	27. Manner of Death 1 ■ Natural 5 □ Pend	ing (A	ate of Injury <i>fonth, Day Yei</i>	28b. Time of Injury		Bc. Injur Worl			28d. Describe h	ow injury oc	ccurrea	
Division or	Attending r death. ector: After by the funer	Certification:	2 Accident Invest	tigation I not be		At home form of	M		Yes 2□	INO	006 1			unt Bauta Mumbar
⋛	or Al fter o	ij.	4 ☐ Homicide deten		iliding, etc. (S	At home, farm, st pecify)	reet, ractory,	Office			City or Tow		umber or nu	ral Route Number,
_	pital ours a eral I		202 Cartifier	ing Physician T-	the best of co	knowledge de-	th cooursed s	at the 41-	no doto -	nd pleas	and due to the	221100/0/ 2	d manner ==	stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		ing Physician: To al Examiner: On the										
	ithin (Mec	29b. Signature and title of certifi		James stated.		29c.	Licens	e number			29d. Date si	igned (Month	, Day, Year)
	£ ≥ £ 8		16 8	7/1/4	4.5					200				
	D		"Tuest	170	10 1	(lham 00=) (Ti	Drint		D219	7 UU		Jı	11y 14,	2000
	•		30. Name and address of perso Smith S. Ho, M					te ?	80. T≤	akoma	Park. Mar	vland 1	20912	
	Sta	te	31. Date filed (Month, Day, Year		Registrar's		. Out	2	,			, /		
	Sta Registr		.1111 1 5			he do	and B							

			Please Type or l					-	_	
			1 - For State of Registrar	Marylan		artment of I rtificate of	lealth and N Death		giene Reg. No 2008	24362
I	Physici //Medic		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Milton GC	LDBERG				2. Date of Dea Month	Day Year	3. Time of Death 7:40 P M
	Examir Funeral Director		109-03-0391 ^¹ X ^{M 2□} F		last birthday) Yrs.	4b. City, Town, or Rock\ If Under 1 Year Months Days		8. Date of Birt (Month, Day Augus t	4c. County of Dea Montgom b, Year) 12, 1912	
	aryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation		- 1-12-17-17-17-17-17-17-17-17-17-17-17-17-17-		10d. Inside City Limits 1 X Yes 2 □ No
	ith the Ma or 28a-f	Funeral Director	Maryland Montgomery 10e. Street and Number	F	Rockvi	10f. Zip Code			10g. Citizen of What C	ountry?
	sath w	eral	229 Hurley Avenue	dent Ever in U.	C 10		20850	ooitu Voo or No	United St	
5-0036	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Was Dece Armed For 1 □ Was Pece Armed For 1 □ Was	rces? 2 No		was becedent on the state of t	dispanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
12-C	in 72 ho r "natur ledical	Completed by	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worked)	king	16b. Kind of Business	/Industry
717	ed with giene. er thar , the N	Som	Elementary/Secondary (0-12) College (1	-4or 5+)		kkeeper	<u></u>		Bookkeepi	ng
yland 2	ould be file Mental Hy arked othe atic event	To Be (17. Father's Name (<i>First, Middle, Last</i>) Abraha	ım Goldk	erg		18. Mother's Nam Elsie	e (First, Middle, Sufer	Maiden Surname)	
<u>a</u>	'ages 1 and 2 should be fi ont of Health and Mental H t: If item 27 Is marked ot y or other traumatic ever		19a. Informant's Name/Relationship (Type. Print) Sharon Light, Niece		26 Ta	ab io na Co	ourt, Silv	ver Spri		906
saitimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from 4 □ Donation 5 □ Other (Specify)		amatanı cia	osition (Name of matory or other pla ebrew Cen	netery 07,	Date /13/08	Staten Isl	
Dall	permit, Depart Import any Inj once.		21. Signature of Funeral Service dicensee	5					uneral Hom	e 20012
F	hysician		23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	ach line.	n. Do not en	ter the mode of dy	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	L	Due to (or as a consequ						
,	icate be executed physician and s the burlat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequor as a consequ				· · · · · · · · · · · · · · · · · · ·		
ō.	certificate be diding physicial ise as the burl		d							
×	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. When Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the law.	Physician/Medical	in the past 12 months?	come pf pregna irth 2 ☐ Feta ant at time of do own	Ideath 3[⊒Ectopicpregnand □ Other <i>(specify)</i> _	cy		23d. Date of de Month	elivery Day Year
records, P	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to de	eath but not resu	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
	The law re ate has bee page 2 sho	Completed	Chronic 1	Leus	Or's	esse			an 24b. Were a prior to death? 2 No 1 □ Ye	
VIII :	sician: certific rector,	Be	25. Was case referred to medical examiner?			Ot	26. Place of Dea			
5 5	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	tion: To	27. Manner of Death 28a. Date		28b. Time o injury	of 28c. Inju	4 Nursing H		dence 6 Other (Sp how injury occurred	ecify)
DIVISION	after deal after deal I Director d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place	of injury - At hong, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	le Hospita 124 hours le Funera letely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the beautifying conditions and manifold the conditions of th	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	th occurred at the to estigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	3+1	Me	29b. Signature and title of certifier	(ND	29c. Licen	se number 06243	5	29d. Date signed (Mor	nth, Day, Year) ZCOS
			30. Name and address of person who completed causes SAYED EISAYYA'D	e of death (Item	1 23a) (Type,	Print) Carax	06243 Dr. Roc	Kuilk,	MD Z	0850
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 5 2008	egistrar's Signa	ture	ali				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Preston Gregory, Sr. July 11 1:16 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 12410 Seabury Lane Bowie Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Ye May 29, 1 Sex M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 231-03-5861 91 Yrs. Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Prince George's Bowie Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any inlury or other traumatte event, If a Medical Expringer must be. 12410 Seabury Lane 20715 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No þ 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C.J. Gregory Sarah Frances Leslie ၀ 19a. Informant's Name/Relationship (Type. Print)
Allen Preston Gregory, Jr. -son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4505 Clearbrook Lane Kensington, Maryland 20895 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 7/12/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonala Viers Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atrial Fibrillation 5years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami and burial-tra Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Bradvcardia Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

Kathyann Walcott

JUL 1 5 2008

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number

D0054099

12201 Plum Orchard Drive, Silver Spring, MD 20904

29d. Date signed (Month, Day, Year)

July 11, 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Paul Geibig July 8 2008 8:28 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel County Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director <u> 185–34–1601</u> 65 June 21. 1943 Pennsylvania Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show
reumatic event, the Medical Examinar must be neithed at Director 1 ☐Yes 2 ☐ No MD P.G. County <u>Bowie</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12401 Kembridge Drive U.S.A. Funeral 20715 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify è Specify: White 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Deputy US Marshal US Marshals Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev ပ္ Eugene Statler Geibig Merrium Stine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Otto M. Neilson (POA) 5651 Hardesty Road, Sunderland, Maryland 20689 ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 12 Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facili Lee Funeral Home Calvert, P.A. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rosepsis days disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Exami Due to (or as a consequence of): attending physician ノン(イ) Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 □Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending 124 hours after death.

• Funeral Director: A

pletely filled in by the fi death. M 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) reidbuh, Mp 718/08 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Situation Bell to 2001 Medical 10 death (Item 23a) (Type, Print) Parkway annapolos, Pro 31. Date filed (Month, Day, Year) Registrar's Signature State JUL Blacks. Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician A^{M} July 24, 2008 4:05 MARY JOSEPHINE HITESHEW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days 1 □ M 2 🖾 F March 21, 1919 Massachusetts Director 018-09-9993 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "Modical Experiment must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Frederick Director Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 115 Record Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Ellen Connolly John Dunne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 115 Record Street, Frederick, Maryland 21701 Kevin Quirk / Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 28, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Li M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Betw Onset and Death Immediate Cause (Final liverticuliti **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner constination if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Ischenic and burial-tran Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical Seizures the as attending properties for use as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 🗷 No Month Year Day 5 ☐ Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 X No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **≥** No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number D0055061 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. DOIE T NAGY, MD 300 WEST NINTH ST; FREDERICK, MD 31. Date filed (Month, Day, Year)
1111 2 9 2008 2. Registrar's Signature State

Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, &

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and w		Usual Residence of Deceden 10a. State 10b. Col		10c.	City, Town	or Location							10	d. Inside City Limits
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and N	_	19a. Informant's Name/Rela	ionship (Type. Print))						ral Route Numl				
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Physician		Immediate Cause (Final disease or condition	_a	cute	CC	rebyo	vas	cul	ar	acc	1 de	w.	^	Oliset and Death
/Medical Examiner		resulting in death)	/ Du	e to (or as a cons	sequence of): (LUOCO		î	1	Down	7			
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	29a. Certifier 1 Certifier (Check only one)	tifying Physician: ¹ Ilcal Examiner: On and	to the best of my the basis of exar manner stated.	knowledge nination and	death occurre	d at the t	opinion, d	and place leath occi	e, and due to tr urred at the time	e, date an	d place, a	ind due t	to the cause(s)
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5		39 Name and address of pe	AHEEN	cause of death	(Item 23a) (Type, Print)	11()	NO.	HA	560 \Tel	WV.	m	0 9	21742
Stat	te	31. Date filed (Month, Day,	Year)	32. Registrar's S	ignature	1	(/	1 - 9-74	11	10,000		*	- 0	, , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Battimore UMMS 8. Date of Birth (Month, Day, Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**Z**F Maryland 70 072 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he marked and 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No by Funeral Director Delaware Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26218 Fire Tower Rd 19973 Sussex 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudy Harriman Belinda Chaffinch ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heath Hitchens - husband 26218 Fire Tower Rd, Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burjal 72 □ Cremation 3 □Removal from State Odd Fellows Cemetery 7/15/2008 Seaford, DE 4 □ Donation 5 □ Othe (Specify) 21. Signature of Funeral & 22. Name and Address of Facility
Cranston Funeral Home Cranstor P O Box 967, Seaford, DE 19973 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aar /Medical Due to (or as a consequence of):

Prolonged Status epilecticus

Due to (or as a consequence of): Examiner 2 moSe pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes No Month Day 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🖊 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Director: After the 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

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ress of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760,

or Attending Physician: Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 R No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 NOther (Specify) #5501CC this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO, M.D.; 5302 CHINABERRYDR., SALISBURY, MD 21801 GREGORIO M 31. Date filed (Month, Day, Year) State 7 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10, 2008 **Physician** 5:15 A M Robert Lee Hall July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Nursing Center Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 26 1926 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 213-22-0849 1 3M 2 ☐ F 81 Yrs. Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County Show r than "natural", or items 23a or 28a-f shov the Me ireal Examiner must be notified at Maryland Calvert Prince Frederick 1 □ Yes Ž No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20678 440 Gott Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 √Yes 2 No if Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white unknown 1 Tes 2 kNo Specify. 2 3 ☐ Widowed 4 ➡ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer L snould be filed Health and Mental Hygie. To is marked other the pr traumatic every 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Hall Everett Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health an
Important: If Item 27 is
any Injury or other trau 440 Gott Road Prince Frederick MD 20678 Paula H. Werfel-daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Asbury Cemetery July 14 2008 Barstow Maryland 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 10000 c 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alheroscerotic Cardio Vascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 ☐ Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 € Unknown mellitus Completed 24b. Were autopsy findings available prior to completion of cause of Dementia 24a. Was an Advance page 2 s autopsy performed death? 1 ☐ Yes 2 1 No certificate 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (SpecIfy) 4 Homicide 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653

DRW 10+1

State Registrar 31. Date filed (Month, Day, Year) 12008

5851-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale Church ton
2008 Signature
112008

ROAD DEALE MD. =

20751

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Sylvia Harris 15, 2008 July 12:05 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick 2295 Sixes Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F September 16, 1928 MD Director 79 217-46-5701 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No an "natural", or Items 23a or 28a-f sl Medical Examiner must be notified Director MD Calvert Prince Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20678 2295 Sixes Road Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examina-1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3√ Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Pearl Purvey Henry Brooks, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2295 Sixes Road, Prince Frederick, MD 20678 Isaac L. Harris - Son 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greater Bible Way Church 7/21/2008 Prince Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Glody Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINOMA 01month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ CA 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA P After this 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 □ Yes 2 □ No death. after death 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a l 🕆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 3 30. Name and address of person who completed cause of death (Item 234) (Type, Print) unsh 31. Date filed (Month, Day, Year) JUL 1 6 2008 32. Registrar's Signature State Registrar

Records, P.O. Box 68760 Division or Vital To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After WIL 2

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

son who completed cause of death (Item Pa) (Type, Print

JUL 1 6

29b. Signature and title of certifier

a) (Type, Print)

rdon, Mo

Baltimore, Maryland 21215-0036

be executed burial-transit and attending physician the for use

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice within 2.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2008 6:15 A M JULY 11 HARRIS DELBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S 7726 NALLEY COURT LANDOVER 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F Yrs AUG 24 1924 MICHIGAN Director 83 189-12-1547 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Director LANDOVER MD PRINCE GEORGE'S 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number **IISA** 20785 7726 NALLEY COURT Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mayes 2 No NAVY If Yes, Give Year or Dates: 1 Never Married 2 X Married BLACK 1 ☐ Yes 2 🗓 No Specify. Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE TRUCK DRIVER 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JUANITA JOHNSON THURSTON HARRIS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7726 NALLEY COURT LANDOVER, MARYLAND 20785 YVONNE HARRIS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEMETERY 8/1/2008 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It's only one cause on each line. Immediate Cause (Final **Physician** VASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 1∐ Yes 2∭ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1466665 11, 2008 00 ķ: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONA M. LESKUSKI M.D. 9200 BASIL COURT SUITE 200 LARGO, MARYLAND 20774 32. Redistrar's State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Year **Physician** 12,2008 0630 /Medical Pame1a Hook 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisburu Kehab & Nursing(lisbur Wicomica Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number-6 Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🗙 F Director Maryland 213-22-9896 80 5-21-1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the <u>Medical Examiner</u> must be matriced. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Director MD Wicomico Hebron 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 305 Lillian Street Funeral 21830 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Linen Work Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hulbert ည Hook Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harris - niece <u> 31586 Largo, Terrace, Salisbury, MD 21804</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7-14-2008 | Hebron, Maryland Hebron Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the dise se, or complete one that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause it each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dan 24 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of eath Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Anatural 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3#P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins M.D. 200 sivic Day, Year) gistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital

2008

JUL 15

State of Maryland / Department of Health and Mental Hygien 2008 24375 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0415 rances Jarvis 07 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Deer's Head Salisbury, Maryland Hespital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 166-07-5617 Yrs. Director 93 5/16/1915 Maryland Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 ehow any njury or other traumatic event, the Marical Examiner must be notified at ance. 10a. State 1X Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 1514 Riverside Dr., Apt. C304 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 □ Divorced white 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland personel/public relations 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bertha Truitt Wilmer T. Townsend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 400 Plummer Dr., Chesapeake, VA 23323 Judy Lassiter/niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1 Burial 2 Cremation 3 Removal from State 7/16/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee ANTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Hert 12 Kerine Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myccardial Jula
Due to (or as a consequence of): **Physician** 3 days Julasction /Medical Examiner CHUTS. erenaty arlesy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed eseprevascular accidu and Due to (or as a consequence of): physician a P.O. Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyper Teusion has autopsy performed? A soythmia, Chronic obstructiveling disease. 10 Yes 25 page Hyperlipidemia 2 **1** No 1 ☐ Yes 2 No 25. as case ferred to medical examiner? funeral director. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 🔀 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by within 24 hours after To the Funerel Dire To the Hospitel filled 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H006606 2008 3.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, MA Deers Head Hospital, TONY GETS CHURS D.0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep Registrar State	partment of Health and N Pertificate of Death	lental Hygi Re	ene g. No. 2008	24376
ì	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
G.	/Medic	al	Sarah G. Johnson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 7,	2008 4c. County of Death	19:35 ^M
E .	Examin	er	Southern Maryland Hospital	Clinton		Prince Ge	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign
L	Director		577-40-4135 1□M 2対F 77 Yrs.	Months Days Hours Min.	6/20/19		intry) ington, DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	laryla shor	or					1y⊒Yes 2□No
	the N 28a-1	Director	Maryland Prince George's Temple Hi	11s 10f. Zip Code	10	g. Citizen of What Co	untry?
	3a or		4311 23rd. Pkwy # 308	20748		nited State	-
	death	Funeral	L	. Was Decedent of Hispanic Origin? (Sp. If Yes, specity Cuban, Mexican, Puerto		14. Race - Amer Black, White	rican Indian,
1215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 □ Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 Yes 2√2 No Specify:	rican, etc.)	Specify: Blad	
2-0	72 ho 'natul	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king I	6b. Kind of Business/	ndustry
2	should be filed within 7 ad Mental Hygiene. marked other than "r matic event, the Mrd	шb	Elementary/Secondary (0-12) College (1-4or 5+)			_	
N	iled v Hygie ther t	S	12 Bure.	au of Engraving	e (First, Middle, M	Government	· · · · · · · · · · · · · · · · · · ·
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Maryland 2	should Ind Men	우		ling Address (Street and Number or Ru		City or Town, State, Z	(ip Code)
Š	and 2: ealth a n 27 is ier trau		Ernest Jerome Johnson Sr./Spouse 431	1 23rd Pkwv. # 308	Temple 1	Hills. Mar	vland 20748
re,	- T = =		20a. Method of Disposition 20b. Place of Disposition			20c. Location - City or	
Ē	mit. Pages bartment of h cortant: If Ite Injury or of		1 to Bunal 2 Cremation 3 Removal from State	ction Cem. 7/12	/2008	Clinton, Ma	aryland
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Licensie	22. Name and Address of FacilityPop	e Funeral	Homes, P.	. A .
n	9 9 E E 6	19		5538 Marlboro pike			Land 20747
	100	9	23a. Part 1. Enter the disease, of complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arre	est,	Approximate Interval Between Onset and Death
¥	Physician		Immediate Cause (Final disease or condition resulting in death)	light lung			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted Insit	Examine	Cause. Enter Underlying Cause (Disease or injury				
ĵ,	execting and in all-tra	Еха	that initiated events c		,		
68/60,	ificate be executed g physician and as the burial-transit	edical	d		7045 VI-0-V		
_	- CD m	Medi	IF FEMALE:				
o n	death certifi e attending id for use as	sician/M	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy	☐Ectopic pregnancy		23d. Date of del Month	ivery Day Year
5	ne dea the ar	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Monar	Day Tour
1	w requires that the de been signed by the should be detached	Phy	Part II. Other significant corliditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
vital Records,	signe d be	d by	acute Kenal failure regiunny		1 □ Ye	es 2☑No 3□Pr	obably 4 Unknown
Ö	w req	Completed			24a. Was ar	24h Ware at	utopsy findings available
Ď	The law rate has be	dwo			autops: perforn	y prior to oned?// prior to oned?//	completion of cause of
g		ပိ	25. Was case referred to medical	26 Place of Dea	1 Yes 2 th (Check only one	P.☑No 1 ☐ Yes	2 No
	Physician: r this certific ral director,	0 0	examiner? 1 Yes 2 No Hospital: I Inpatient 2 ER/Outpati	Othor		nce 6 ☐Other (Spe	cify)
סר	ding Phys	Ë	27. May ner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at		w injury occurred	
0	endlr ath. or: Af he fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
UIVISION	or Att ter de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
ב	urs af eral D				ļ.		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	aut occurred at the time, date and place investigation, in my opinion, death occu	r, and due to the ca rred at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	omple	Mec	29b. Signature and title of entire	29c. License number	2:	9d. Date signed (Mont	th, Day, Year)
			I Wal-	D0055/20		Tuly & zir	18
	13).		30. Name and address of person who completed cause of death (Item 23a) (Type			July 8 200 In Di Zer	
	Je Sto		Richard Palmer up 1328 Southern ale	um Il suche 310	western,	bon Di Zer	32
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Stenature				
	Registr	ar	JULI TO LOS AND AND AND AND AND AND AND AND AND AND				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 858PM Margaret N. Jones 2008 JU /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Doctor's Hospital Lanham Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1□ M 21 F Months Days Hours Min. 04/06/1934 74 180-30-6345 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD FG Landover 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7624 Allendale Drive 20785 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Danestic Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Nowlin Bessie Scipio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winford L. Jones - Son 9306 Dubarry Avenue; Lanham, Maryland 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Ft. Lincoln Cemetery 07/19/2008 Brentwood, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Sign 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part . Briter the disease, or com shock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine RTENSIV Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Box 68760 P.0. Records, of Vital

Funeral

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death

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantinar must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite, any injury or other traumatic event, Ital Mudical Evantment.

Physician

/Medical Examiner

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physician

Maryland 21215-0036

Baltimore,

law requires that the death certificate be executed signed I icate has been si , page 2 should b certificate Hospital or Attending Physician: director this funeral (After Division in 24 hours are: the Funeral Director: Af the To the within

Medical completely

Certification:

31. Date filed (Month, Day, Year) State Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

32. Registrar's Signature

and manner stated.

6 ☐ Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERCY OBAMOGIE, m.D. 7323A HANDVER PLW, GREENBELT, m.D.

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Joshua Drew James 1- For State Certificate of Death Registrar 2. Date of Death Physician/ Month Day July 21, 2008 0800 hrs ^{⊲i}cal Examiner 4c. County of Death 4b. City, Town, or Location of Death Name (if not institution, give street and number) Anne Arundel 403 - C Old Stage Road Glen Burnie 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Hours Director Country) 1 M Usual Residence of Decedent 10d. Inside City Limits Yes 2 No or 28a-f show must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 21061 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes Yes 2 No specify: Divorced If Yes, Give Year marked other than "natural", c event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 ment of Health and Mental Hygiene. tant: If item 27 is marked other th or other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname SHERRI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cert 20a. Method of Disposition 2 Cremation HANOVER, MY Donation 5 Other Specify FAMILY FUNERAL HEME Approximate Interval eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician failure. List only one cause on Between Onset and Medical Death a Methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical 23a,27,28a-f, perME, G882 8/7/08 TT X UNPENDED AMENDED attending physician or use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of performed? death? 2 ✔ Yes 2 No 1 1 Yes 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Natural Yes 2X No 24 hours after death Funeral Director: Director: 7/21/08 2 Accident Investigation 28f. Location (Street and Number of Bural Route Number, City or Town, State) 403-C old Stage Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be (Specify) Home determined Glen Burnie, 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature July 22, 2008 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 9 2008 Registra

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	- negistrar	71111100110 01 2 01111	Heg. No.	
cian dical	Decedent's Name (First, Middle, Last) ROBERT WILLIAM KEISER		2. Date of Death JULY 24, 2008	3. Time of Death 6:30P M
iner	4a. Facility Name (If not institution, give street and number) 9095 ELMER COURT	4b. City, Town, or Location of Death LA PLATA	4c. County of CHARL	
il r	5. Social Security Number 220-66-7258 6. Sex 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 7-9-1956	9. Birthplace (State or Foreign Country) OHIO
	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
ector	MD. CHARLES	LA PLATA		1 ☐ Yes 21 No
Funeral Director	10e. Street and Number 9095 ELMER COURT	10f. Zip Code 20646	10g. Citizen of W	/hat Country?
ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	I. 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		e - American Indian, c, White, etc.
þ	1 Never Married 2 Married 1 Yes 25 No If Yes, Give X Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		WHITE
Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king U.S.GO	
Comp	College (1-4or 5+) College (1-4or 5+) P.RO	JECT ENGINEER		ORDINANCE
To Be (17. Father's Name (First, Middle, Last) ROBERT EDWARD KEISER		e (First, Middle, Maiden Surname AGNES HADDEN	· ·
		iling Address (Street and Number or Ru 5 ELMER CT. LA		
	1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TRINIT	position (Name of rematory or other place) Y MEM.GARDENS 7	-26-08WALDORF	•
2	21. Signature of Fuseral Service Licensee M00479	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MD. 20	SERVICE, P.A.	
	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
1 [Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	eal (Ancer		41/2700
	Sequentially list conditions, b.			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last			
an/Medical Ex	Due to (or as a consequence of):			
Mec	IF FEMALE:			
Physician/	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy	B⊟Ectopic pregnancy 5 ☐ Other (<i>specify</i>)	23d. Date More	e of delivery nth Day Year
d by Pr	Part II. Other significant conditions contributing to death but not resulting in the	undertying cause given in Part I.		ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Completed by			24a. Was an 24b. V	Were autopsy findings available prior to completion of cause of
Com			performed?	death?
Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	th (Check only one)	
. To	27. Manne of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing H	ome 5 Residence 6 □Othe 28d. Describe how injury occurr	
ation	1, ☑Natural 5 ☐ Pending (Month, Day Year) Injun 2 ☐ Accident investigation	/ Work? M 1 □ Yes 2 □ No	,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause(s) and ma irred at the time, date and place,	anner as stated. and due to the cause(s)
N	29b. Signature and title of certifier	29c. License number	$\frac{29d. Date signed}{7/2}$	d (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Typ	P. Pylint) PCELYARY Ray	1 Clinica,	14)
tate strar	31. Date filed (Month, Day, Year) JUL 2 9 2008 Registrar's Signature	ule	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Clinton Frederick Knapp, Jr. JÜly 12, 2008 10:11a ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral X**□ M 2□ F Months Days Hours Min. 090-20-1390 79 Director July 29,1928 New York Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County show "natural", or items 23a or 28a-f shov die al Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6980 Indian Head Hwy., Unit 8 20616 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1945-1 ☐ Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced White 1966 Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Photographer U.S. Government marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or nature. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Frederick Knapp, Sr. Nellie Bemins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie L. McGuigan Daughter 7622 Indian Town Rd., King George, Va. 22485 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) July 14,2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Metropolitan Funeral Sérvices 21. Signature of Funeral 22. Name and Address of Facility
Williams Funeral Home, M00668 4270 Hawthorne Rd., Indian Head, Md. e, or complications that ca List only one cause on ga Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or hea sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (f **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lated as a second cause). Examiner certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy õ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the aid be detached 1 Yes 2 No detached 9☐ Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Honknown plnous Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 25. Was case referred to medical examiner? After this certificate 1□ Yes or Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 1 Inpatient 2 ER/Outpatient 3 DOA ျ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending investigation Injury death. 2 Accident Funeral Director: rtely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after the Hospital within 24 hours 11 Lectrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the 29b. Signature

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

istrar's Signature

2008

State of Maryland / Department of Health and Mental Hygien 1 - For Stata Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Jul Barbara Ann Kline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
June 24,1933 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Hours Min 217-28-6217 75 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Madical Examinar must be notified at Director Washington County Hagerstown 28a-f 10e. Street and Number 10f. Zip Code 13402 Windsor Dr. items 23a 21742 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounts Payable Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) 2 should be f and Mental H William Martin Barnes Sarbara Leonia H. Barbee Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 Beverly J. Barnes-sister 17803 Timber Lane Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 7-16-2008 | Hagerstown, Maryland | 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Due to (or a

Due to (#

Hospital:

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death

11 Inpatient

28a. Date of Injury (Month, Day Year)

4☐ Pregnant at time of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

and

attending physician

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Certification; To Be Completed by Physician/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

burial-transit ate has been signed by the atte page 2 should be detached for

ours after death.

neral Director, After this certifical filled in by the funeral director, 25. Was case referred to medical examiner? 1 Tes 27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide within 24 hours a To the Funeral [Medicai 29a. Certifier 29b. Signature and title of certifier

3H-7

31. Date filed (Month, Day, Year) State Registrar 6

30. Name and address of person

Immediate Cause (Final disease or condition resulting in death)

in the past 12 months?
1 Yes 2 No
9 Unknown

2XN0

5 Pending

investigation

2008

6 Could not be determined

IF FEMALE:

completed cause of death (Item 234) (Type, Print) Malik gistrar's Signature

No. 24a. Was an autopsy

2 1 Yes

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Tyes

24381

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Peath

Year

4 | Unknown

1 ☐ Yes 2 No

Maryland

14. Race - American Indian, Black, White, etc.

White

Sand Blasting Company

8:08 PM

Year

2008

4c. County of Death

Washington 9. Births

10g. Citizen of What Country?

U.S.A.

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

3 Probably

13

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated A Section of the desired manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1/41

3 Ectopic pregnancy

3 DOA

5 Other (specify)

29d. Date signed (Month, Dey, Year) 2008

1500 Pennsylvania Avenue

Hagerstown, MD 21742

2 ER/Outpatient

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 11 2008 7:45 Harry Ernest Kelbaugh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Director 91 July 31, 213-14-8310 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evansing must be notified at Baltimore 1 ☐ Yes 2 XNo Director MD Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3703 Laburman Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ **X**o \$ Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
South Baltimore 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Hospital Director of Radiography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Bertha Garfiela Cole Harry Richard Kelbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7023 Deerfield Road Pikesville, MD Ross Kelbaugh/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/1672008 1 № Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Forest Ridge Church Cem Foreston, MD 21. Signature of Funeral Service License Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) holangiocarcinoma **Physician** weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending I for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. ed by the 9 Unknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ð icate has been siç , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No After this funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

WJL 20

N. Charles St. balto. Md 21205 Rile 6701 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State 5 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

und

29c. License number

29d. Date signed (Month, Day, Year)

July 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24383 State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 9, Naomi KLEIN **Physician** 2008 10:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Springvale Terrace Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 16, 1 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1□M 2XF Washington, DC 1911 Director 97 578-44-3542 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Silver Spring Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20910 8505 Springvale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 No If Yes, Give Year or Dates: ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Secretary 12 permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important; If Item 27 Is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simon Snyder Bertha Weiner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 2185 Sanborn Drive, Sedonia, AZ 86336 19a. Informant's Name/Relationship (Type. Print) Cynthia Lane Tyler, Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery | 07/13/08 Adelphi, MD 4 Donation 5 Dother (Specify) 21. Signature of Fineral Service License Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Peripheral Vascular Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Assisted 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Living 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.0. or Vital Records, Division

the burial-transit and attending physician certificate be use as t for been signed by the should be detached funeral After To the Hospital or Attendle within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. To the Hospital within 24 hours a To the Funeral C

show

"natural", or Items 23a

Maryland 21215-0036

Baltimore,

Medical

erwoein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32809

29d. Date signed (Month, Day, Year)

10313 Georgia Ave., Suite 306, Silver Spring, MD Segal, M.D., <u>Herman B.</u> 32 Registrar's Signature 31. Date filed (Month, Day, Year)

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \be

24384

			Certificate of Death	Reg. No.	2000 24304
	Di di	Decedent's Name (First, Middle, Lest)		2. Date of Death Month Day	3. Time of Death
-	Physician /Medical	Ronald S. Koehler		July 7, 200	08 10:45pm
1	Examiner	4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or	Location of Deeth 4c.	County of Death
	3	Collingswood Nursing Center	Rockville		ontgomery
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days Hours Min.	(Month, Dey, Yeer)	Birthplace (State or Foreign Country)
•	Director	328-24-6420 /6	Yrs.	Aug. 19, 19	31 Illinois
	pue ≱	Usuel Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
	Aaryte Aaryte Or				1 ☐ Yes 2 🖾 No
	with the Ma t or 28s-1 s be notified Director	Maryland Montgomery Boyds 10e. Street end Number	10f. Zip Code	10a. Citi	izen of What Country?
	A P D				
	within 72 hours after deeth with the Manyland ene. than "natural", or frems 23s or 28s-f show the Madical Examiner must be notified at sympleted by Funeral Director	18132 Truffle Lane 11. Merital Status 12. Was Decedent Ever in U.S.	20841 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexicen, Puer		ited States 14. Race - American Indian,
0	T F F F	Armed Forces? 1 Never Married 2 Married 112 Yes 2 No If Yes, Give THITT			Black, White, etc.
Š	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 21X No Specify:		Specify: White
5	led within 72 hor lygiene. ner than "natura nt, the Medical is Completed	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation	deing 16b. Ki	ind of Business/Industry
7	e e e e e e e e e e e e e e e e e e e	Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	ixing .	
7	Agien Con	4	Controller		Industry
פַ	d of H	17. Fether's Neme (First, Middle, Last)	18. Mother's Nat	me (First, Middle, Maiden	Sumame)
Ş	Men Men To	Walter E. Koehler		nderson	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	1	b. Mailing Address (Street and Number or Ri		
aî	leeith m 27 her t	Traci Koehler Johnson (Daughter)	18132 Truffle Lane,		
0	ges tof H	20a. Method of Disposition 1 ☐ Burial 2 区Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place)	July 15.	ocation - City or Town, State
Ë	tmen tant: jury		politan Crematory	2008 Ale:	xandria, Virginia
3ai	Depar Impor Impor Inpor Inpor Inpor Inpor	21. Signature of Funeral Service Licensee	22. Name and Address of Facility De 10 East Deer Park		Home
	00 = 0 G	Jobert XIChMol	Gaithersburg, MD 2	.0877	•
	4	23a. Pert1. Enter the disease, or complications that caused the deeth. Do shock, or beart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
يز	Physician	() (- 11		Onset and Death
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	= grrythni	a	mymori
			a consequence of):		
	ficate be executed sphysicien end is the buriel-trensit edical Examiner	b			
	icate be executed physicien end is the buriei-trensit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to (consequence of):		l I
68760,	sicie e buri	Cause (Disease or injury that initiated events	consequence of):		
89	The law requires that the death certificate be executed ate has been signed by the attending physicien end page 2 should be detached for use as the buriel-trensit Completed by Physician/Medical Examin	resulting in death) Lest	consequence or).		
Box	h certi ending r use a	d			1
<u> </u>	es that the death ce igned by the attendi be detached for us, by Physician/	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco	uee contribute to the cause of death?
Р. О.	at the Iby the stach	Cerebersala acc	a de t	1 □ Yes 2	No 3 Probably 4 Unknown
Ś	es this igned be de		1 Clar		
פ	equin	Dementia		24a. Was an auto performed?	available prior to
Ö	as be	- JOHN TO			completion of cause of death?
<u> </u>	: The law require cete has been si page 2 should Completed			1 ☐ Yes 2	Z No 1 ☐ Yes 2 1 No
Division of Vital Records,	clan: ertific ector,	25. Was case referred to medical examiner?		ath (Check only one)	
\leq	Attending Physician: or death. ector: After this cartific by the funeral director, iffication: To Be (1 ✓ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C		Home 5 Residence	
ב	rng P where	1 Naturel 5 Pending (Month, Dey Year)	Time of 28c. Injury at Work?	28d. Describe how inju	ry occurred
<u>s</u>	eeth. or: A the f	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
₹	ital or Attending Physics select deeth. al Director: After this colled in by the funeral director: Certification: To	4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Suicide 5 Suicide 4 Suicide 5 Suicide 6 Suicide 7 Suicide 6 Suicide 6 Suicide 6 Suicide 6 Suicide 6 Suicide 7 Suicide 6 Suicide 6 Suicide 6 Suicide 6 Suicide 6 Suicide 7 Suicide 8 Suicid	farm, street, factory, office	City or Town, State	nd Number or Rural Route Number, e)
	ptrain ours ours ours ours ours	29a. Certifier 12 Certifying Physician: To the best of my knowledge	on doubt accommod at the time, data and older	a and due to the course/o	and manner as stated
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours eleter deeth. To the Funeral Birector: After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Physician/Medical Certification:	29a. Certifier 12 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination e end manner stated.	nd/or investigation, in my opinion, death occ	urred at the time, date an	d place, end due to the cause(s)
	ompi	29b. Signeture end title of certifier	29c. License number	29d. Da	ate signed (Month, Dey, Year)
	,,,,	Des Salve We	1006243	55 7	1/8/2008
	>	30. Name end eddress of person who completed cause of death (Item 23e) (Type Print)	^ -	1
		SAYED ELSAYYAD IOILO	Molecular D.	Rockvil	11.MD 20850
	State	31. Dete filed (Month, Dey, Year) . Registrer's Signeture	1 15	*	
	Registrar	JUL 1 5 2008 See 15	Grave I		
-	111.40 D. AME		Ø.		

Physic /Med Exam **Funera** Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, $\widetilde{\mathcal{L}}$

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	1 - State Registrar			Certifica	ite of Dear	th				
ın ai	Decedent's Name (First, Midd	_{le, Last)} Josephine I	Murrell A	At Lee			Date of Death Month July	Day Year 22, 2008	3. Time of Death 9:45 P	
er	4a. Facility Name (If not institution	n, give street and number)	4b. Ci	ty, Town, or Location	on of Death		4c. County of Dea	ith	
8	Solomons Nursing (omons	dor 24 Um I	0 Data of Disth	Calvert	ab alara (Obsta au Francisco	
	5. Social Security Number 227-38-8512	6. Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. last b 95	Yrs. Month		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, June 26, 19	Year) C	thplace (State or Foreign ountry) inia	
	Usual Residence of Decedent 10a. State 10b. Count	/	10c, City, Toy	wn or Location					10d. Inside City Limits	
ruieiai Dilector	MD Calver		Hunting	town					1 □Yes 2 No	
5	10e. Street and Number			10f.	Zip Code		10	g. Citizen of What C	ountry?	
0	3326 Holland Cliffs				2063			JSA		
	11. Marital Status 1 □ Never Married 2 ☑ Ma	12. Was Deceden Armed Forces rried 1 ☐ Yes 2 ☒	?		cedent of Hispanic pecify Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		1 ☐ Yes	2⊠ No Spec	cify:		Specify:	White	
D E	15. Decede	nt's Education	16	a. Decedent's U	sual Occupation		1	6b. Kind of Business		
25	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or	.5.1	(Give kind of life. DO NO	work done during i use retired)	nost of worki	ng			
5	-4-	4		Choir Dire	ctor			Church		
pe completed by	17. Father's Name (First, Middle	, Last)			1	other's Name	(First, Middle, M	aiden Surname)		
2	Thoma	s Edward Murrell					Hall	ie Howard		
	19a. Informant's Name/Relation	ship (Type. Print)	19	b. Mailing Addr	ess (Street and Nu	mber or Rura	al Route Number,	City or Town, State,	Zip Code)	
	W. Kipling At Lee,	Jr Son		3326 Holla	and Cliffs Ro	ad, Hunt	ingtown, MD	20639		
	20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation	3 Removal from State	comof	of Disposition (I ery, crematory	lame of or other place)		Date 2	0c. Location - City o	r Town, State	
	4 Donation 5 Other (tropolitan C	rematory	7/23/2	008 /	Nexandria, VA	\	
	21. Signature of Funeral Service	e Licensee		22. Name	and Address of Fa	acility				
_	Radip 4.	Servell		Sewell F	ineral Home,	P.A., 1451	Dares Beac	h Rd., Prince Fr	ederick, MD 20678	
olcal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or a	s a consequence s a consequence s a consequence	e of):						
r ily sicializmedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★ No 9 □ Unknown		2 Fetal dea at time of death	th 3⊟Ectopi 5⊟ Other	c pregnancy (specify)			23d. Date of d Month	elivery Day Year	
בת הא ני	Part II. Other significant condi	. 1	but not resulting	in the underlyin	g cause given in P	art I.		Be. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
combiered by							24a. Was ar autops perform 1 Yes 2	24b. Were prior to death'		
ב	25. Was case referred to medic examiner?					Place of Deat	h (Check only on	9)		
2	1 Yes 2 No	Hospital: 1 Inpa				Nursing Ho		nce 6 Other (Sp	pecify)	
	Z L Modidani	tigation	Day Year)	. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe ho	w injury occurred		
		mined 20e. Place of I	njury - At home, etc. (Specify)	farm, street, fac	tory, office		28f. Location (St. City or Town		Rural Route Number,	
Medical Certification:	(Check only 2 Medica	ing Physiclan: To the bes al Examiner: On the basis and manner	of examination		tion, in my opinion	, death occur	red at the time, d	ate and place, and d	lue to the cause(s)	
2	29b. Signature and title of certif	21 Sar	Ac		29c. License num D5224		2	9d. Date signed (Mo	nth, Day, Year)	
	30. Name and address of personal forms of the second secon	Barth, M	. D.		Ŧ	rince	prode	rick M	0	
e r	31. Date filed (Month, Day, Yea JUL 2 9 2	32. Regis	strar's Signature	bark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lenora E. Lankford 7358 PM /Medical 4a. Facility name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUISBURY Recional mo WICEMICO Medica Social Security Number Sex O If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 K 526-30-2255 87 **Director** California 08-13-1920 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Nedical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 1109 S. Schumaker Drive Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify Specify: ₩ Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) none Manager Sears & Roebucks 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) \$2 should be fith and Mental I Wilbur Patterson Nancy Patterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau once. B. Edward McClellan/son PO Box 1380, Dubois, Wyoming 82513 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State △□ Donation 5 □ Other (Specify) Manokin Presbyterian 7/15/2008 Princess Anne, Maryland Fignature of Funeral Seg Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United States of Injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) has been signed by the e 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy 2 No 2 No 1 ☐ Yes 1 □Yes or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient After this 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manyner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 □ Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1041721 09/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAVLO STEPMAN E. SHORE 400 SALISBURY DR 31. Date filed (Month, Day, 32. Regi Year) ar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

			For State Registrar	State of Maryl	-	artment of He <i>rtificate of D</i> e			liene 200 (3 24387
	Physici	an	Decedent's Name (First, Middle,)					Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g	Lemore give street and number)	Jr.	4b. City, Town, or Le	ocation of Death	07	10 200 4c. County of Dea	1 2 1 -
	Funeral Director	<u>.</u>		Ce at the Sex, 1 M 2 F 7. Age (In	Lake yrs. last birthday, 53 Yrs.		If Under 24/Hrs. Hours Min.	8. Date of Birth (Month, Day	n 9. Bi	Thico rthplace (State or Foreign Country)
	yland now at		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	he Mar 18a-f sl	Director		omico .	Salis	1			10-0'4'	1 ∏ Yes 2 ☐ No
	3a or 3	i Dir	10e. Street and Number	ire Dr		10f. Zip Code \	01		10g. Citizen of What C	A.
	tems 2	Funeral I	11. Marital Status	12 Was Doodont Ever	in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f show adkal Examiner must be notifiled at	by	1 Mever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? i 1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 212 No	Specify:		Specify: 2	Black
15-0	"natur "natur edical I	leted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind of Business	· ·
WHIS Lemin 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	bishwa:			Fenwi	ck Inn
Due Jud	ould be filed Mental Hygid arked other attc event, th	Be	17. Father's Name (First, Middle, La	Á .	~ (1	8. Mother's Name	(First, Middle,	Maiden Surname)	\
aryle	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic	오	19a. Informant's Name/Relationship	C. Cemo		ng Address (Street an	HEIL nd Number or Rura	I Route Numbe	r, City or Town, State,	, Zip Code)
7 <u>8</u>	1 and 2 Health a tem 27 is		Gilda D. Lemi			7 Fsquir		Salis		D 31801
+15 more	0 0 - -		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State		matory or other place))	ate	20c. Location - City of Delmar	
\sqrt{a}	permit, Pag Department Important: I any injury o	ľ	21. Signature of Funeral Service Like			2. Name and Address		1100		Isabellast.
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	Physician	22 1	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Firum disease or condition	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		MLAR (Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a cor		ocost, C		NO W	PT	
do		Jer	Sequentially list conditions,	b	nse tuence of					
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	lelivery Day Year
Division or Vital Records, P.O	w requires that the de been signed by the a should be detached i	þ	Part II. Other significant condition	s contributing to death but no	t resulting in the	ınderlying cause given	ı in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
I Reco	siclan: The law r certificate has be irector, page 2 sh	Completed						24a. Was autop perfo 1∐ Yes	an 24b. Were prior to death	
Vita	siclan: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0 T F D 10 11 11	Othor	26. Place of Death			
J Or	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	III JUDON	4 Li Nursing Ho		dence 6 Other (Sp now injury occurred	pecity)
Sion	tter dir death. stor: Al	icatio	2 Accident investigat 3 Suicide 6 Could no	tion		M 1 Ye	es 2 No	20f Logation /6	Street and Number or	Pumi Pouto Number
Div	saer saer al Direc ed in by	Certification:	4 Homicide determine	building, etc. (S)		reet, factory, office		City or Tou		ridia riodie Nambol,
	To the Hospital or Attending Physician: within 42 hours are dean. To the Funeral Director. After this certifical completely filled in by the funeral director, p.	edical (Physician: To the best of my caminer: On the basis of exa and manner stated.						
	With Tot	Σ	29b. Signature and title of certifier			29c. License		-	29d. Date signed (Mo	onth, Day, Year)
	OIM	ĺ	30. Name an indress of person w	no completed cause of death	(Item 23a) (Type	1 000_ , Print)	58410		1/10/0	8
			GHURAM WAR	L'y COASTAL	- HOSPI	CR PU	Box	1733	SALISAU	ay morisor
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 14	2008 32. Halistran's S	Signature	pole				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24388 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 07 **Physician** 2008 0950 Martin Marv Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ALLEGANY MEMORIAL HOSPITAL CUMBERLAND 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 4, 1925 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ F MD Director 220-16-6391 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show f Health and Mental Hygiene. Itlem 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medioal Examiner must be notified at 1,∏Yes 2 ☐ No MD Allegany Cumberland by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Fairview Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ XNo Specify: 3X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard McGann Elizabeth Catherine Nolan McGann ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia Pittman 14800 Old Hancock Rd, daughter Cumberland MD 21502 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rocky Gap Veterans Cemetery 7/25/2008 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Syl 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic non-small cell carcinoma disease or condition resulting in death) 1 Cale /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Physician/Medical as attending properties for use as IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been si page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2☑No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760; certificate After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. ŏ the Hospitai 2

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

A, State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 2 9 2008

Gamar UI



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 Seton Drive

D0023371

Suite

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 JULY 16, **Physician** 4:15 A M WILLA CANBY MORGAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY GAITHERSBURG ASBURY METHODIST VILLAGE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 4 / 13 / 19 11 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 VF 97 WEST VIRGINIA 232-26-5741 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show 1 Yes 2 No GAITHERSBURG MD notified Director MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number a or 20877 USA 211 RUSSELL AVENUE permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must to Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOSPITAL RN17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IVA SHRIVER C. M. CANBY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 1750, HEDGESVILLE, WV 25427 CLAETUS CANBY/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JULY 18 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE CEMETERY MARTINSBURG, WV 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME. P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Hown Xxelio 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death YEARS Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown SEVERE ARTHRITIS Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2□XVo death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo 1 ☐ Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0020148 7/23/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)



DR. STEVEN H. DOLINSKY, 911 RUSSELL AVE., GAITHERSBURG, MD 20879

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:26 PM 15-2008 PO Florence н. Malone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Coastal Hospice at the Lake If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 7/15/1916 Washington, DC 92 Director 216-50-9830 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits fshow 10a. State 10b. County r 28a-f shov notified at 1 ☐ Yes 2 XNo Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or any injury or other traumatte event, the Medical Examiner must be a 30523 Fox Chase Drive 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ XNo Specify: white Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Holbrook (unknown) Virginia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30523 Fox Chase Dr., Salisbury, MD 21804 James T. Malone/husband Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Allen Cemetery 7/18/08 Allen, MD 21. Signature of Funeral Service ichnsee Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FICUTE CARRBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to for as a consequency of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 paonths? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an page 2 s certificate I 1 Yes 2/ No Physician; funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1/2 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after death. ■ Funeral Director: A filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DOX 1737 SHEISBURYUMS 21707 WARY Hustin COASTAL 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Prysician Medical Examinor As. Facility Name (if root institution, pice street and number) As. County Hospital Hagerstown As. County Death As. County Hospital Hagerstown As. County Death Death Death As. County Death De	
Physician Medical Lean Browning Miller As Felichy Name (Front institution, give dreef and number) As Felichy Name (Front institution, give dreef and number) As Felichy Name (Front institution, give dreef and number) As Felichy Name (Front institution) As Felichy Name (Front institu	24391
Washington County Hospital Fundal Director 200—22-5827	3. Time of Death
Value Personal P	ace (State or Foreign
Susie Burger—daugnter 20a. Method of Disposition Date 20c. Location - City or Town	ylvania
Susie Burger—daugnter 20a. Method of Disposition Date 20c. Location - City or Town	d. Inside City Limits 1 X Yes 2 □ No
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A Donation 5 Other (Specify) Greenhill Cemetery 7-19-2008 Waynesboro, F 21. Signature of Funeral Service Licensee 12. Name and Address of Facility Douglas A. Fiery Funer 1331 Eastern Blvd. North Hagerstown, M 1331 Eastern	
Physician Medical Examiner 23a. Part 1. Enter the disease, so commindations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (indicated Cause (indicated Cause)) and disease or condition resulting in death) and disease or condition resulting in death). Last 25a. Part 1. Enter the disease, so commindations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. And the property of	
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25. Was case referred to medical examiner? 1	osy findings available inpletion of cause of
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) = 700 M 21742	
State Registrar 31. Date filed (Month, Day, Year) 32. Tigisrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:35P MCKENDRICK JULY 16, 2008 CHARLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.15,1948 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 159-38-7503 59 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evanding the natified at once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 12 Oak Tree Lane Apt. F Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) computer specialist computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna T. Sabodich Charles Patrick McKendrick Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Oak Tree Lane Apt. F, Williamsport, Md. 21795 Janette McKendrick - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/17/08 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euro ral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acrite myocare minules **Physician** /Medical Due to (or as a consequence of Examiner peroscient Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year for 5 Other (specify) signed by the a ☐Yes 2☐No P.O. g D Unknown g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature as 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0H-5 Ron Miller, M. D., P. O. Box 210, Mt. Airy, Md. 21771 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 2008 **JUL 17** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11 33 PM **Physician** MAY 2008 BETTY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) Days **Funeral** 1 🗆 M 2 🕱 F 214-28-5737 76 Nov.10,1931 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo or 28a-f PA Waynesboro Franklin 10g. Citizen of What Country 10f. Zip-Code 10e. Street and Numbe permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 migury or other traumatic event, the Medical Examiner must he monone. USA 12290 Scott Road 17268 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 X No 1 ☐ Yes 2XNo Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) crossing guard public school system 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Elmira Middlekauff Howard Cecil Hause 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12290 Scott Rd., Waynesboro, Pa. 17268 Lloyd A. May - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/08 Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME 1415 E.Wilson Blvd., Hagerstown, Maryland 21740 P. f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PNEUMONIA ONE MONTH **Physician** /Medical Due to (or as a consequence of): **Examiner** TWO MONTHS MYELOID ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of uttending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 5 Other (specify) signed by the at ald be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes cate has been sign r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 TYes certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA ٥ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 K Natural Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Af

filled in by the fu · death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number Teizabeth alice Shiffithe Mechael Doctor 063957 16 2008

WH-5

Hospitai

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O. I

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

ELIZABETH GEIFFITHS

165 ORLEANS STREET 32. Registrar's Signature 2008

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

ROOM 186

Amended Item 30 per Phy. 07/15/2008 Carroll Co., wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thomas Lee Munch 2008 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye. Nov 13 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑** M 2□ F W.VA 1936 Director 71 220-34-6969 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show : if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 2535 Old Taneytown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 1964 Specify: \$ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westminster Lawn Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental litem 27 is marked or Charlotte Fern Suttle Julian E. Munch ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2535 Old Taneytown Road Westminster, MD 21158 19a. Informant's Name/Relationship (Type. Print) Jennifer Munch/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/19/2008 permit. Pages 1 Department of H In portant: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State Hampstead, MD Carroll Cremation, Inc 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sit ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE CARDIOMYOPATHY ISCHEMIC **Physician** /Medical Due to (or as a consequence of) Examiner CRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending I hours after death.

uneral Director: A

sly filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire completely filled in by 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29c. License number D0017695 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ျှ Holou, M.D-WJL 12+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Ave. ARDALLAH J. HELOU, M. D. CARROLL HOSPITAL CENTER WESTMINSTER 173 21158 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		lis State of Maryland / Department 1- For State Certificate Registrar		Reg. No. 2008 2439
Physicia dical Exami		1. Decedent's Name (First, Middle,Last) Anthony Wayne Mullis	2. Date of I Month July 12	Day Year 9:55p
9		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral		University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24Hrs. 8. Date of	Baltimore f Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		219 02 0725	Months Days Hours Min.	19, 1974 ForeignNorth Caro
and Show any ace.		10a. State 10b. County 10c. City, Town or Lo Maryland Anne Arundel Severn	ocation	10d. Inside City Limits
arylan 8a-f sh at onc	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h the M 3a or 2 otified		1312 Ava Road	21144	USA
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
s after rral",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	Specify: White
1215-0036 Id be filed within 72 hours after fental Hygiene. arrked other than "natural", event, the Medical Examiner	Completed		dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)	16b. Kind of Business/Industry
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	dmo	12 Surv		Engineering
D 21215-00, should be filed with and Mental Hygiene 7 is marked other thatic event, the Med	Be Co	17. Father's Name (First, Middle, Last) Wayne L. Mullis	18. Mother's Name (First, Midd	,
Z1Z Z1Z wuld be Mentz mark c even	To B		Pamela Wrig ailing Address (Street and Number or Rural Route	
M 2 sho alth and m 27 is aumati			20 Sylvan Vue, Dagsboro	, DE 19939
BAILUTOCE, MID 21213-0030 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State crematory of	sposition (Name of cemetery, rother place) litan Crematory July 14	20c. Location - City or Town, State Alexandria, VA
Salt Sermit. Departr Import Injury		1 1 20100	2. Name and Address of Facility Francis J. Collins Fun	
Physician	2.0	23a. Part I. Enter the disease, or complications that caused the death. Do not en	E00	
/Medical xaminer	Y	failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
	_	Sequentially list conditions, if any, leading to immediate b		
	Examiner	cause. Enter Underlying Cause		
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.		
bU, tte be executhysician and eburial - tr	Jical	unpended x #Sperme,7-15-08	PMW MoCo	
(bU,	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
death certificate be exemple a set of or use as the burial of or use as the or use of or use as the or use of or use of or use or use of or use or use of or use or use or use of or use	Physician/Medical	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
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res that th signed by be detach	à	Part II. Other significant conditions contributing to death but not resulting in t		oid tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
of Physician: The law require offer this certificate has been sineral director, page 2 should b	Completed	<u> </u>	24a. W	
he law te has ge 2 sl	dmo		P	utopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No
certificat ector, pag	a)	25. Was case referred to medical	26.Place of Death (Check only one)	es 2 No Tes 2 No
hysician: this certif al director,	O.	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other Nursing Home 5	Residence 6 Other:
tendin eath or: A	ation:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury (Month, Day, Year) Unknow Unknow 28b. Time Unknow	1840400000	ribe how injury occurred clist collided with van
To the Hospital or Attendii within 24 hours after death To the Funeral Director: / completely filled in by the fi	Sertification:	Suicide 6 Could not be determined (Specify) Major Road / Highw		on (Street and Number or Rural Route Number, City vn, State) I Road and Old Mill Road, Severn, MD
To the Hospital of within 24 hours all To the Funeral E completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place, and due to the digation, in my opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
0 = 0 =	§.	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Son With	- 1	110.0 - 1h. 110	O.C.M.E.	July 13, 2008
\$ 15 E 10 E		wigorde The Strill		
To with		30. Name and address of person who completed cause of death (Item 23a)	1 Penn Street Baltimore MD 21201	<u> </u>
15		30. Name and address of person who completed cause of death (Item 23a)	1 Penn Street, Baltimore, MD 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Depart	ment of Health and N ficate of Death		0000 01007
			1. Decedent's Name (First, Middle, Last)	ilcate of Death	Reg. No.	2 Time of Dooth
	Physicia		Richard Anthony Milroy		July Da	5, 2008 8:50 PM
-	/Medic Examin		,	b. City, Town, or Location of Death	40	c. County of Death
-A ⁽¹⁾			Cloredu convarescent a nemas centre	Crofton Under 1 Year If Under 24 Hrs.	8 Date of Birth	Anne Arundel
	Funeral Director			Ionths Days Hours Min.	/Month Day Year	9. Birthplace (State or Foreign Country) 930 Virginia
	TO		Usual Residence of Decedent			10d. Inside City Limits
	larylaı shov	ō	10a. State 10b. County 10c. City, Town or Locati			1 Ves 2 No
	the M	Director	1101) 10110	polis 10f. Zip Code	10g. C	Citizen of What Country?
	h with	a Di	222 South Cherry Grove Ave.	21401	Uni	ted States
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	i within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Evantual or nofitied at	by Fi	1 □ Never Married XX Married	Yes XX No Specify:		Specify: White
5-0036	2 hour		15 Decedent's Education 16a Deceden	t's Usual Occupation	16b.	Kind of Business/Industry
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Maryland	e d ta	To Be	John Martin Milroy	Dorothy	•	,
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altimore,	Pages 1 and nent of Healt int: If item 2: iry or other		20a. Method of Disposition 20b. Place of Dispositio cemetery, cremation 3 ☐ Removal from State			Location - City or Town, State
<u>=</u>	permit. Page Department o Important: If any injury or once.					entwood, Maryland or Funeral Home,Inc.
Ba	perm Depe Impo any i					napolis, MD 21401
П			23a. Part 1. Enter the disease, or complications to a caused the death. Do not enter t shock, or heart failure. List only one caus on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition	myltonio		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	l		
		ē	Sequentially list conditions, if any leading to immediate. Due to for as a consequence of the control of the c			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c.			
Ö,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
28760	ficate be executed physician and s the burial-transit	dical	d			
Rox	certi iding se a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ctopic pregnancy	7	23d. Date of delivery
	ed for u	Physician/M	in the past 12 months? 1 □Yes 2 □ No 4 □ Pregnant at time of death 5 □ O	other (specify)		Month Day Year
J.	hat the	Phy	9 ☐ Unknown Part-H: Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ecords,	w requires that the de been signed by the should be detached	d b	l'ashere te thrine		1 ☐ Yes	2 No 3 Probably 4 Nhknown
င္ပ	law req as beer 2 shoul	lete			24a. Was an	24b. Were autopsy findings available
Y	The ate h	Completed		-	autopsy performed 1 ☐ Yes 2	
Ital	ding Physician: The this certificate funeral director, pag	BeC	25. Was case referred to medical examiner?		ath (Check only one)	
0	Attending Physician: r death. ector: After this certific by the funeral director,	ဍ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		lome 5 Residence	6 ☐ Other (Specify)
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DIVISION	Atten ector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)	t, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
5	ital or urs afte ral Dir lled in	Cert				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated.	eccurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the	Mec	29b. Signature and tith of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	mtl			D57028	(7-11-08
	Frako	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		A = = = = =	2000 20101
	Sta	to.	Aditya Chopra M.D. (coo Ridgely 31. Date filed (Month, Day, Year) 32. Pysistra's Signature	Avenue #231	Annapoli.	5 MD 21461
	Sta Registr	ar	31. Date filed (Month, Day, Year) JUL 1 4 2008 32. Pristrar's Signature	and a		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI, PII 25 perME 9881 7/30/08 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 429 DM 2008 Grace Mancuso 12 JULY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE LNIVERSITY OF MARY LAND MED CENTER 8. Date of Birth (Month, Day, Jan. 1, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**V**□ F Washington, DC 214-42-4213 66 Jan. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show items 23a or 28a-f shov ner must be notified at 1 XYes 2 □ No Rehoboth Beach Delaware Sussex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 120 Strawberry Way 19971 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White 9 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of r than " College (1-4or 5+) Elementary/Secondary (912) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. Marvland Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Newell Marvin Sloan Smi th Helen Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 Strawberry Way Rehoboth Beach, DE John A. Mancuso -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 7/13/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LEVERE AURTIC REGURGITATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown BILEKITIS LYMPHOMA with resulting 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No PERFORATION 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ithin 2 the I and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S Greene Street, Baltimore, MD 21201 Chaudh

State Registrar 31. Date filed (Month, Day, Year) **JUL** 1 5 2008

32 Registrar's Signature

Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not institution, give street and number) Ada Facility Name (If not instit	Day 2008 Year 3:40 AM C. County of Death Montgomery 9. Birthplace (State or Foreign
Au Facility Name (If not institution, give street and number) Au Facility Name (If not institution, give street and number) Casey House-Montgomery Hospice Au Facility Number Au Facility Nu	lc. County of Death Montgomery
Casey House-Montgomery Hospice Funeral Director 5. Social Security Number 577-34-2454 Usual Residence of Decedent 6. Sex 1	Montgomery
Funeral Director 5. Social Security Number 5. Social Security Number 577-34-2454 6. Sex 1 Months Days Hours Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Months Days Min. Security Number 6. Sex 1 Mont	9. Birthplace (State or Foreign
Director Usual Residence of Decedent Street, 1980 Prs. Feb. 1,	(Country)
TO The state of th	928 Washington, DC
	10d. Inside City Limits
Maryland Montgomery Silver Spring	1 ☐Yes 2 K No
Maryland Montgomery Silver Spring Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 110g. C	Citizen of What Country?
1 3409 Hallaton Court 20906	nited States
3409 Hallaton Court 20906 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 1 Never Married 2 Married 1 Yes 2 No	14. Race - American Indian, Black, White, etc.
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9 1 3 ₩ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b.	. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator 16b. Most kind of work done during most of working life. DO NOT use retired) Administrator	ntgomery County
The part of the pa	blic School System
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10 E. Deer Park Drive, Galtin	
23a. Part1. hter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Crus (Find disease o ondition resulting in death) Metastatic Breast Cancer a. Metastatic Breast Cancer	
Evaminer	
Sequentially list conditions, if any, leading to immediate b. Diabetes Mellitus Due to (or as a consequence of):	
Due to (or as a consequence of): Due to (or as a consequence of):	
Due to (or as a consequence of):	
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X to go s	23d, Date of delivery
So the policy of	Month Day Year
O e f f g g g g g g g g g g g g g g g g g	
9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc	co use contribute to the cause of death?
COLOGO State Sta	2 No 3 □ Probably 4 □ Unknown
24a. Was an autoform and autofo	24b. Were autopsy findings available prior to completion of cause of
1 Yes 1 Yes 24a. Was an autopsy performed to yes 24a. Was an autopsy performed to yes 1 Yes 24a. Was an autopsy performed to yes 24a. Was an autopsy performed to yes 25. Was case referred to medical examiner? 25. Was case referred to medical 26. Place of Death (Check only one) 25. Was case referred to medical 26. Place of Death (Check only one) 27. Was case referred to medical 28. Place of Death (Check only one) 29. Was case referred to medical 20. Place of Death (Check only one)	d? death? ☑No 1 ☐Yes 2 ☐No
1 Yes 24 25. Was case referred to medical examiner? 1 Yes 2 Man Yes 2 M	se 6攵Other <i>(Specify)</i> Hospice
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Output 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how in the control of the	
27. Manner of Death 28d. Date of Injury 28d. Date of Injury (Month, Day, Year) 28d. Date of Injury (Month, Day, Year) 28d. Date of Injury Work? 28d. Date of Injury M 1 □ Yes 2 □ No	
27. Manner of Death 1	et and Number or Rural Route Number, State)
29a, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause	and manner on stated
25. Was case referred to medical examiner? 1 Yes 2 Xi No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence e and place, and due to the cause(s)	
and manner stated.	I. Date signed (Month, Day, Year)
29b. Signature and title of certifier / 29c. License number 29d.	
D64615 J	July 11, 2008
30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)	•
Decree William D64615	•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3008 11:10 A M **Physician** B Jr. Price Sunny /Medical Hity Name (If not institution, give street and number) 4b. City, Jown, or Location of Death of Death Examiner MATA MEDICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 216-22-3549 82 09/07/ 1925 **Director** Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It whe dies It aminer must be notified at 1XYes 2 ☐ No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2025 B Wedgewood Court 20601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Black Specify δ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Navel Surface Elementary/Secondary (0-12) College (1-4or 5+) Warfare Center Custodian 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sunny Price Sr. Martha မ В Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Yates/ Daughter 12865 Yates Place LaPlata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Episcopal 07/19/08 | Newport, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 19120605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** recemanas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of) burial Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 1 □Yes 2 □No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed certificate Vital 2 🗆 No 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1X Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Division of this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 2 □ Accident 5 Pending n 24 hours after death.

e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No investigation Could not be 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, uate and place, and due to the cause(s) and making. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and making stated. completely (Check only one) within 2 29d, Date signed (Month, Day, Year) 29b. Signature and title of celtifie 29c. License number address of person who complet 30. Name and ed cause of death (Item 23a) (Type, Print) Waldorf Md 20602 Atul OST OFFICE R Va 31. Date filed (Month, Day State Year) JUL 16 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 12 2008 **Physician** 9:16 pm Roy Cornelius Prebble, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George 1411 Airport Lane Accokeek If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **X** 4 2 □ F 577-32-7336 July 26, 1927 Washington D.C. Director 80 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Prince George Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ; must be r 20607 U.S.A. 1411 Airport Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1X Yes 2 No 1944— If Yes, Give Year or Dates: 1966 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Completed by 3 Widowed 4 Divorced 1966 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Civil Engineer jes 1 and 2 should be filed v of Health and Mental Hygie If item 27 is marked other t or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy C. Prebble, Sr. Gladys Nellie Buffington 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1411 Airport Lane, Accokeek, Md. 20607 Corinne S. Prebble permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) August 26, 2008 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 e, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis Immediate Cause (Final disease or condition resulting in death) COLON **Physician** ANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) man oulle July 14, 2008 D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz, M.D. 7525 Greeway Ct. Dr., Greenbelt, Md. 20770 31. Date filed (Month, Day, Year) JUL 1 5 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05463 2008 24402 William Richard Paul State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Pħysician/ 1. Decedent's Name (First, Middle, Last) 1153 hrs July 16, 2008 **Medical Examiner** William Paul 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Fruitland 507 Havward Ave. If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 214-70-6821 52 09/09/1955 ce Manyland 1.X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 X Yes 2 No Maryland Wicomico Fruitland with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 507 Hayward Ave. 21826 USA 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death Never Married 2 Married 2 X No Yes 0 white hours after Yes 2 x No specify: Specify: 4 X Divorced If Yes, Give Yea Widowed ⋧ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 cook restaurant marked other tic event, the Me 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Paul Hilda Booze Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JoAnn Lewis/significant other 507 Hayward Ave., Fruitland, MD 21826 it: If item 27 is 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth 7/23/08 Jerusalem Cemeterv Parsonsburg, MD Donation 5 Other Specify: 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, perME, g881 7/30/08 TT X UNPENDED by the attending physician ached for use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Month Year Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 Unknown Diabetes mellitus Completed s peen s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? No Yes 2 No Yes 2 1 1 certificate 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other, DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient this 1 Yes မ No 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 No · death. Director: d in by the Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

the Hospital or Attending Physician: 24 the within ٥

30. Name and address of person who completed cause of death (Ifem 23a) Assistant Medical Examiner Russell Alexander MD. 31. Date filed (Mark

29b. Signature and title of certifie

Registrar's Signature

and manner stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 17, 2008

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et the E	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ie (First, Middle, Maid	en Surname)	
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shound h		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. N	failing Address (Stre	et and Number or Ru	ral Route Number, Cit	y or Town, State,	Zip Code)
pattimore, invary fattor Z permit. Pages 1 and 2 should be filed w pepatrient of Health and Mental hygie Important; if item 27 is marked other it any injury or other traumatic event, it once.	1	Veronica K. Gregory	-daughter	971	9 Deanewo	od Lane. H	agerstown,	MD 2174	0
che He He He		20a. Method of Disposition	20		isposition (Name of crematory or other p			Location - City or	
Page ry or		1. Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					-2008 Hag	erstown.	Marvland
rmit. Pages partment of portant; If it portant; If it y Injury or ce.		21. Signature of Funeral Service License					uglas A. F		
Depa Impo		Murda A	Line		1331 Eas	tern Blvd.	North Hag	erstown,	MD 21742
	1	23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	cation that caused the d	eath. Do no	t enter the mode of o	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final	ASUSIO	0					Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of)	:				
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deal deal	100	in the past 12 months? 1 ☐ Yes No	4 ☐ Pregnant at time 9 ☐ Unknown		5 Other (specify,			Month	Day Year
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riter th	ü	27 Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Tir	ne of 28c. In	njury at Vork?	28d. Describe how in	njury occurred	
endiin eath. or: A	atic	2 Accident investigation				□Yes 2□No			
r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farn ecify)	n, street, factory, offic	ce	28f. Location (Street City or Town, St	t and Number or F tate)	Rural Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exar	knowledge, nination and	death occurred at the	e time, date and place by opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner and place, and du	as stated. ue to the cause(s)
the hin 2, the hin 2, the f	Medical	one)	and manner stated.						
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Z11 . A		30. Name and address of person who co		(Item 23a) (T	ype, Print)	Start	11000	f - 100	21740
5H-10		MARK BATON, M.		= , Dr	IIIEIDM.	OXCU,	11200	CMN IN	10111
Sta Registr		31. Date filed (Month, Day, Year) JUL 1 6 20	32. Pogistrar's S	ignature A	1	/	0	1	
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9008

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1850 Doris Julia Peregoy 08 2008 July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 11 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days 1□M 2□√ 80 217-24-9402 1928 June Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show "natural", or items 23a or 28a-f shovedien Examiner must be notified at 1 ☐ Yes 2X No Carroll Finksburg Director MD10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21048 2907 Constellation Way Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Mamied 1 ☐ Yes 2 ☐ No Specify 3altimore, Maryland 21215-0036 Š White 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be is marked o Mary Bentz Edward Vincent Gunther, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Finksburg, MD 2907 Constellation Way JoAnne Miller/daughter Item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/1592008 20a. Method of Disposition Department of F Important: If Ite any injury or ot once. N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) Printed Augustadin Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 pa/5 **Physician** 04/899:08 disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 movi 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 21-1 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 3 DOA 1 TYes 1 🔲 Inpatient this uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No s after death. 2 Accident the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) State JUL 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 7/14/08 State of Maryland / Department of Health and Mental Hygiene 24405 For // 14/00 State Registrar Amend#16bperFHPGC, HH Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 10 ay **Physician** Mary Bernice Pringle-Hunter 2101A JUN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 225-32-6297 1 ☐ M 2 🕱 F Vre Director 84 06/22/1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at XYes 2 □ No MD Springdale Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20774 USA 9313 LaVall Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 XWidowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry vent, the Medical 15. Decedent's Education (Specify only highest grade completed) Changing Times 12th than College (1-4or 5+) Changing Cook is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Saltimore, Maryland Be James Poindexter Lizzie Bell Chappell Health and Men any Injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1 and 2 James H. Pringle Jr./Son 9313 LaVall Dr. Springdale, MD 20774 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State mportant: If Sunflower Cemetery 07/19/08 Nathalie, VA 4 Donation 5 Dother (Specify) 21. Si nature of Fun Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St.NE Washington, DC 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician lassive resulting in death) /Medical Due to (or as a consequence of): Examiner monge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examine burial-tran and Box 68760 attending physician for use as the buria certificate be Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.O. I the detached 9□Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ρ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has death : 1 ☐ Yes this certificate 2 No or Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 mpatient 2 ER/Outpatient 3 DOA ဥ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Division Hospital or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 302, Lanham, MD. 20106 Thomas Ko, N 31. Date filed (Month, Day, Year) 8100 GoodLuck Rd. mD.

Registrar

State

JUL 1 4 2008

DHMH 17 Rev 1/2001

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 24406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day 2008 Year JULY LAWRENCE 11:20 PM PRINCE 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours **Director** WASHINGTON DC 579-56-6790 63 JÄN 16 1945 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. the Merlinal Evanton. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1√□Yes 2□No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3403 SUMMIT COURT 20018 USA Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 2□No ARMY Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No þ Specify. Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT OFFICER GOVERNMENT 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES E. PRINCE SARAH C. CUTHBERTSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 DEBRA PRINCE-BUNN/SISTER 13804 PINE NEEDLE COURT UPPER MARLBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State QUANTICO CEMETERY 4 □ Donation 5 □ Other (Specify) 7/18/2008 | TRIANGLE, VIRGINIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner ADVANCED MULTIPLE MYELOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) The law requires that the death certificate be executed DIABETES MELLITUS Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical attending for use as If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2 s Jas autopsy perform 1□ Yes 2**X** Na the Hospital or Attending Physician; completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 □t/npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41752 JULY 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERGIT I. SCHOELLMANN M.D. 1500 FOREST GLENN ROAD SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUL 1 5 2008 Registrar

			1 - State of Maryland / Dep	artment of Health and Mertificate of Death		ne No. 2008	24407
,	Physic /Medi		Decedent's Name (First, Middle, Last) Michael Kevin Parker		7/10/		3. Time of Death 9:15 P M
	Funeral	ner	4a. Facility Name (If not institution, give street and number) Prince George's Hospital 5. Sodal Security Number 6. Sex 7. Age (In yrs. last birthday) 1 △ 5 5 0 0 2 / 2 1 ☑ M 2 ☐ F 5 2 Yrs.	4b. City, Town, or Location of Death Cheverly if Under 1 Year if Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death Prince Ge ar) 9. Birthp County	lace (State or Foreign
	Director show at at	ž	143-30-9342 33 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	7/30/19		Od. Inside City Limits
	3a or 28a-f	I Director	MD Prince George's 10e. Street and Number 8003 Allendale Drive	Landover 10f. Zip Code 20785	10g.	Citizen of What Coun	1 ⊠ Yes 2 □ No try?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Pican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	filed within 72 h Hygiene. Ither than "natu ant, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Aud	dent's Usual Occupation kind of work done during most of work DO NOT use retired) itor	king	. Kind of Business/Inc	lustry
aryland	2 should be fill and Mental H Is marked oth aumatic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) Rosser Lee Parker 19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Maili		e (First, Middle, Maid E Lughes ral Route Number, Ci	·	Code)
<u>6</u>	t. Page ntment c ntant; If njury or		20a. Method of Disposition 1 Burial 2 Stremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition State Metropol	Allendale Dr., La sition (Name of matory or other place) Ltan Crematory 7/1 2. Name and Address of Facility	3/2008 A.	. Location - City or To Lexandria,	VA
g	Depar Impo any Ir		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	asch's Funeral Hom	ne, P.A.	4739 Balti Hyattsvill	more Ave. Le, MD 20781 Approximate Interval Between Onset and Death
	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death and in 24 hours after death and in 24 hours after death and in 25 hours after death and in 25 hours after death and in 25 hours after death and in 25 hours and in 25 hours are death and in 25 hours at the burial-transit in 25 hours are death and in 25 hours are dea	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nuy orrest			
O. Box o	the death certify the attending ached for use as	Physician/Med		⊒Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delive Month	ry Day Year
cords, r	equires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the use of the second strategy of	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
וומו חפכו	an: The law r tificate has be or, page 2 sh	e Completed	Hute curonary Sylldreme Hypertension 25. Was case referred to medical	20.51	24a. Was an autopsy performed 1 Yes 2	prior to cor death?	osy findings available npletion of cause of 2 No
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Ty the Funderal Director. After this certificate has been signed by the attending ping the presence of the funeral director, page 2 should be detached for use as to obtain the funeral director, page 2 should be detached for use as the funeral director.	Certification: To Be	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatier 27. Mann 1 Death 1 Helatural 5 Pending investigation 2 Accident Hospital: Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) Injury	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 ☐ Residence 28d. Describe how in	e 6 □Other (Specify)
2	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /		4 Homicide determined 25e. Flace of injury : At nome, farm, str building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	City or Town, St	a/e) and manner as et	atad
	To the Ho within 24 To the Fu To the Fu completel	Medical	29b. Signature and title of certifier 29b. Signature and title of certifier	29c. License number DOVYS(6 2	red at the time, date	and place, and due to Date signed (Month, 1)	the cause(s)
	Sta	te	30. Name/and address of person who completed caux of death (Item 23a) (Type, BOM C 2 31. Date filled (Month, Day, Year) 32. Registrar's Signature JUL 1 5 2008	Frint) Horpital	·		
	Registra	ar	JOL I O COMO DE DE MAN				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** 0050 a^M July 12, Parsons Harry Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 828 S. Schumaker Dr., Apt. 104 Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/24/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 XM 2 ☐ F 215-20-0054 Maryland 83 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ¥ Yes 2 □ No Director Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 828 S. Schumaker Dr., Apt. 104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 **X**Yes 2 ☐ I If Yes, Give Year or Dates: 2 🗆 No Army 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. white \$ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lineman/trouble serviceman DP & L Power Co. 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margie Ennis Harry Edward Parsons Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 828 S. Schumaker Dr., Apt. 104, Salisbury MD 21804 Harry B. Parsons/son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 Cremation 3 Removal from State Wicomico Memorial Salisbury, MD 7/17/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, or Attending Physician;

the burial-trans physician à signed t certificate has page 2 s funeral director After this hours after death. neral Director; A within 24 hours a

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tro it sites Examination to train

72 hours after

should her and Mer

permit, Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

completely State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of verson vilo co

29a. Certifier

(Check only one)

Medical

and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

13428. Divisial

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 24409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Month 9:35PM YNTHIA 12008 Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** House ARROLL Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Year Days Hours 1 □ M 2 □ F Director 040-30-2088 July 9, 1936 New York Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be 1 of Iting at 1 □ Yes 2 No Director MD Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2983 Duvall Road 21797 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2XMo 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Sheffield Smith Jean Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Friedhoff/daughter 5811 Farmgate Court Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Crematory: 07/15/08 Beltsville, MD 21. Signature of Funeral Serv 22. Name and Address of Facility Soing Home Cremation Service P.O. Box, 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Perneral Director: After this certificate has been signed by the attending physician and elely filled in by the furnerial director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 D Ectopic pregnancy 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? 1 □ Yes 2 □ No perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mamy

16

31. Date filed (Month, Day, Year)

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MD

gistrar's Signature

			For State Ragistrar	State of M	1arylan		artment of Hertificate of D			ene2 () (g. No.	18	24410
	Physici		1. Decedent's Name (First, Middle, Linds e		Reid,	Sr.			2. Date of Death Month July 1	O, 200	Year 08	3. Time of Death 11:26 A M
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or			4c. County		
3	Funeral Director					last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			ace (State or Foreign try) MD
	P .		Usual Residence of Decedent		140- 00						1	0d. Inside City Limits
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	the M	Director	10e. Street and Number				10f. Zip Code	11	10	ng. Citizen of V	Vhat Coun	try?
	h with	al Di	101 Plum Poi	nt Road			20	0639		USA		
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, if a Mudical Exa	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? ¶No		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Blac	e - Americ k, White, v: B1a	etc.
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	and 2 lealth m 27 i		Leslie Gross/I	aughter	205 1	-	Box 8:	33 Hun		n, MD		
Battimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 ti eny injury or other tra 9002.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ity)	. 0	Edmon	d's UMC	7/1	8/2008	Ches.	Bch	., MD
Ball	permit Depart Import eny in		21. Signature of Funeral Service Lice Glosup G.	Sewell		1					Fre	e d.,MD2067
1			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	nplications that caus y one cause on each	ed the deat line.	th. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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	and recute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec	quence of):						
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9		Aedic	DE SENALE.									
P.O. Box	The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	Ectopic pregnancy Other (specify)				ite of delivionth	ery Day Year
	s that med by e deta	y Pr	Part II. Other significant conditions			_			23e. Did tol	bacco use con		he cause of death?
ords	w require been sig should b	ted t	Possible Bo	wel re	n For a	tion	and se	P51'S	1 🗆 Yı	es 2 No	3 Prol	pably 4 (4 Unknown
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Division of Vital Records,	safor At safter d al Direct ed in by	Certification:	4 Homicide determine	28e. Place of building,	etc. (Speci	iome, farm, st	reet, factory, office		City or Tow		ber or Hur	al Houle Number,
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		Physician: To the be aminar: On the basis and manner	s of examin				urred at the time, d	late and place	and due	to the cause(s)
	With	Σ	29b. Signature and title of certifier $ \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad $	c. Sur	ina.		29c. Licens	e number 50653		7 - 10		-
	r		30. Name and address of person who 5 % 51 - De			m 23a) (Туре	Print) Gyo Ruced	an .c.	surar		075	1
V	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 6 2008	Status 32. Reg	istrar's Sign	ature)					

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- "any injury or other traumatic even."

Physician /Medical **Examiner**

burial-tran Division or Vital Records, P.O. Box 68760, attending physician use as t signed by has

To the Hospital or Attending Physician: hours after within 24 Pro the Fu

1- State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 7/16/08 per FH Certificate of Death Reg. No. Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Richard 15, Leon Renner Sr. 2008 РМ July 1:52 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 311-C North Colonial Drive Hagerstown Maryland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 23,1934 5. Social Security Number Sex M 2 F Age (In yrs. last birthday) 9. Birthplace (State or Foreign 73 220-28-7723 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits Maryland Director Washington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311-C North Colonial Drive 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes ♣6. Ho-If Yes, Give Year or Dates:1952-1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Blast Cleaning Equip. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Herman Renner Irene Rebecca Provard ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311-C North Colonial Drive, Hagerstown, Md. 21742 Beverly M. Renner Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Qedar Lawn Memorial Pk: 07-18-08 Hagerstown, Maryland 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, Md. 21. Signature of Funeral Service Licenses R. hoel Brady 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): 124eas disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 40 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA After this 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCorneck Nedicol Michael 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical **Examiner**

Funeral Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show ns 23a or 28a-f show must be notified at 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is in any injury or other traum once.

3altimore, Maryland 21215-0036

Physician /Medical **Examiner**

burial-tran attending physician for use as the buria ate has been signed by the a page 2 should be detached

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Phewithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral WJZ

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year °4 25:€ Charles Leonard Ross July 10 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center Carroll Westminster 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours **★**□ M 2□ F 60 Jan 05 1948 577-64-5328 DC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1⊈Yes 2 No **Funeral Director** MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Charles Street 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1⊠Yes 2□No If Yes, Give Year or DateVietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Random House 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Ross Sarah Lawson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Frisby/daughter 809 Washington Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 07/18/2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Eternal Hope Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee U 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Draeus o earl . Coronavy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dichety Nellity autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asir MD35 711 07/11/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Rd. Suite 100, Westminster, MD. 21157 Mo Kutar 826 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Glesm & Agan JUL 15 Registrar

24413

3. Time of Death

3:16 p

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Yes 2 No

Year

Prince George's

14 Race - American Indian

White

Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

Panama

2008

USA

Specify:

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Ye JUL 1 5 2008

32. Registrar's Signature

6	t.		1 - For State RegistrarAMD#23b,perM	State of Maryla 0,7-15-08,BW,Mb(ertificate of I			eg. No. 2008	24414
	Physici	an	1. Decedent's Name (First, Middle, La					Date of Deat Month	Day Year	3. Time of Death
2.00	/Medio		JESSIE 4a. Facility Name (If not institution, giv	L. RICH	IE	4b. City, Town, or	Location of Death	JULY	12, 2008 4c. County of Dea	
	LXaIIII	ICI	WASHINGTON ADVE		L		MA PARK		MONTGOM	
	Funeral		5. Social Security Number 6. S	V∏M 2∏F	rs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(Year) C	rthplace (State or Foreign country)
	Director		231-36-2615 Usual Residence of Decedent	7	/			MARCH 1	0,1931 V	IRGINIA
	show	_	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	he Ma	Director	MD. PRINCE	GEORGES		MT. RAINI	ER		0.00	1 XYes 2 No
	with t		10e. Street and Number 3001 QUEENS C	HADEL DD		10f. Zip Code 207	710	'	Og. Citizen of What C	,
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	U.S.A.	erican Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, I'm Marikeal Evanthar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:	nicari, etc.)	Black, Whi	te, etc. BLACK
15-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	ı (Giv	edent's Usual Occup	during most of work	ing	16b. Kind of Business	:/Industry
12	within iene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	•		CONSTRU	ICTION
d 2	e filed al Hyg other ent, I	BeC	17. Father's Name (First, Middle, Last,)		LABORER	18. Mother's Name	e (First, Middle, I		CIION
ylar	should be ind Mental marked o	To E	CHARLIE	RICHIE			Ç	SUSIE	HALL	
ë	12 sho hand 7 is m traum		19a. Informant's Name/Relationship (r, City or Town, State,	
	1 and Health tem 27 other to		MARY SMITH/S			3 LaSALLE cosition (Name of ematory or other place			, MD. 2078 20c. Location - City of	
E E	Pages rent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		ematory or other place RS CREMATO	i	-2008	RIVERDAL	F MD
Baltimore,	permit. Pages 1 and 2 should be filed wit Department of health and Mental Hygien Important; If item 27 is marked other th any injury or other traumatic event, I'm once.		21. Signature of Funeral Service Licer	See	i	22. Name and Addre	ss of Facility		EMATORIUM,	
	10200		23a. Part 1. Enter the disease, or com		0091	801 CLEVE	LAND AVE.	, RIVER	DALE, MD.	20737
	Physician	i a	shock, or heart failure. List only Immediate Cause (Final	one caus on each line.	2000	la	To all	1002A	110	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cons	equence of:	2	11 4	cer pe		mules
- All	Examiner	_	Sequentially list conditions.	b. Con	ges	live i	Heavi	fai	Mire	mon hos
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):	2.11h.	e H			Means-
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			IF FEMALE:	23c. If yes, outcome of preg	nancy	/			23d. Date of de	olivany
P.O. Box	death cert e attending d for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No.	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		Month	Day Year
<u>.</u>	at the	Phys	9 🗆 Unknown	9 🗆 Unknown				1		
ds,	signed	ģ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown
Records,	w require s been signal	etec		nabello	me	litte		24a. Was a		
Be	Fnysician: The law this certificate has ral director, page 2 :	Completed						autops perfori	sy prior to med? death?	autopsy findings available completion of cause of
Vital	ertifica ector, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 □ Yes h <i>(Check only on</i>		5 2 DNO
of .	rnysi this c	2	1 ☐ Yes 2 【No	Hospital:			4 LI Nursing Ho		ence 6 ☐ Other (Sp	ecify)
on.	th. : After ; funer	tion	27. Manner of Death 17 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	Worl	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division of	er dea ector by the	Certification:	3 Suicide 6 Could not be determined		home, farm, s			28f. Location (Sa City or Town	treet and Number or F	Rural Route Number,
ِ ۵	urs after or articles in Illed in						6.4			
	To the nospiral or Attending Physician: The law requires that the death cer, within 24 hours after death. To thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea ination and/or	ath occurred at the tir investigation, in my o	me, date and place, ppinion, death occur	and due to the or red at the time, d	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	vithir To th comp	Me	29b. Signature and little of certifier	1. 1	/	29c. Licens	e number	N / 2	29d. Date signed (Mor	
	7/		d ilm	ar of		1)2	8920	Maylard	7-1	13-2008
-	V		30. Name and address of person who	completed cause of death (It	em 23a) (Type 73	19 A +	tannus	· Park	Eway P	embelt -
	Sta	te	31. Date filed (Month, Day, Year)	32 pegistrar's Sig	nature	9 15	·- incope	1 100/1	1)	1),001/
	Registra	ar	JUL 1 5 21	108 January	13. P					
DUM	H 17 Dov 1/20	101			46.					

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 0842 AM 07 2008 Abeysiri Ranasinghe 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MED CENTER BALTEMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 26, 1 Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 ☐ F 69 Sri Lanka 1938

10f. Zip Code

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

20904

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

State Government Employee

10d. Inside City Limits

10g. Citizen of What Country?

16b. Kind of Business/Industry

State Government

14. Race - American Indian. Black, White, etc.

Specify: South Asian

Sri Lanka

18. Mother's Name (First, Middle, Maiden Surname)

1 ☐ Yes 2 X No

10c. City, Town or Location

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates:

College (1-4or 5+)

Silver Spring

Funeral Director 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 Completed by permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or a

RANGHE

1 - For State Registrar

10a. State

Maryland

10e. Street and Number

Usual Residence of Decedent

10b. County

1523 Ivystone Court

1 ☐ Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

12

17. Father's Name (First, Middle, Last)

Montgomery

15. Decedent's Education (Specify only highest grade completed)

Physician

Examiner

/Medical

Physicia /Medic **Examin**

cate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

> 3 Regi

	To B	Dasanayake Banda	Ranasinghe		Kehelpanna	ala Peram	nune Kuma	riamv
		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street				
		Sudammi Ranasing	he (Daughter)	1523 Ivystone	Ct., Silve	er Spring	MD 209	04
		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 [20b. Plac	ce of Disposition (Name of netery, crematory or other place	Date		Location - City or	
		4 □ Donation 5 □ Other (Special		Levinia Cemet	ery 7/19/0	08 Mt.	Lavinia	, Sri Lanka
ouce.		21. Signature of Auneral Service Lice	ee	22 Name and Addre Metropoli	ss of Facility tan Funera.	l Service	2	
		23a. Part1. Enter the disease, or con	nplications that caused the death.	Do not enter the mode of dyir	St., Alexa	andria, V espiratory arrest,	A 22310	Approximate Interval Between
ın		Immediate Cause (Final	y one cause on each line.					Onset and Death
ai er		disease or condition resulting in death)	a. CUTANEOUS T Due to (or as a consequer	nce of):	M WITH SYSTE	ente tivo	WENEUT	3 yrs
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequen	nce oi).				
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	a Ex	resulting in death) Last	Due to (or as a consequer	nce of):				
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	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome pf pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	1		23d. Date of del Month	ivery Day Year
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İ	Completed by					24a. Was an autopsy performed? 1 Yes 2 2 34	' I death?	topsy findings available completion of cause of
	Be (25. Was case referred to medical examiner?			26. Place of Death (C			
	은	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER	3/Outpatient 3 DOA Oth	er: 4 Nursing Home	5 Residence	6 □Other (Spe	cify)
	ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	8b. Time of lnjury 28c. Injur Wor 1 □	yat 280 k? Yes 2∐No	d. Describe how in	jury occurred	
	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined		e, farm, street, factory, office	281	. Location (Street City or Town, Sta	and Number or Ru ate)	ıral Route Number,
	edical (29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurred at the tir n and/or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	Ž	29b. Signature and title of certifier		29c. Licens	e number	29d. E	Date signed (Mont	h, Day, Year)
		Nudeo	white 1	MD 17	1403	r	1 12	2008
		30. Name and address of person who NAD IA CHAUDZI		S. GREENE S	ST BANTIN	IORE MO	21201	
sta stra		31. Date filed (Month, Day, Year) 20	08 Registrar's Signatur	foot				
1/20	01							
				ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day SOMERS, JR. 11:10 AM July R. 14, 2008 ALLEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8 North First Street Crisfield Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Days 65 218-40-7421 Oct. 7, 1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 8 North First Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Trucking Employee Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Somers Mary Virginia Riggin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 North First Street - Crisfield, MD 21817 Bobbie Jean Somers (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) unnyridge Memorial Park July 17, 2008 Crisfield, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility BRADSHAW &

Mary Roth Bradshaw Pruit

23. Name and Address of Facility BRADSHAW &

Mary Roth Bradshaw Pruit

306 West Main Street - Crisf

23a. Part1. Errie he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 West Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final PRFARCTION disease or condition resulting in death) MYDCAPDIAL Due to (or as a consequence of): ASCVD Due to for as a nonsequence of: Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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signed by the a

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funeral director.

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After t

Hospital

Physician

/Medical

Examiner

Director

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Completed

Be ဥ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at

filed withir Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, any leading to infine de-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit Exam

JE FEMALE:

Physician/Medical

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Be Completed

Certification: To

Medical

State

Registrar

24a. Was an autopsy perform 1□ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
Yes 2 No 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

D48098

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) July 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

<u>Vijay Karumbunathan, M.D.</u> 201 Hall Highway, Crisfield, MD 32. Resistrar's Signature

JUL 1 6 2008

5 Pending

investigation

6 Could not be determined

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygient Important: If item 27 is marked other tha any Injury or other traumatic event, the lange. Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed or Attending Physician; within 24 hours after death.

To the Funeral Director: A

State of Maryland / Department of Health and Mental Hygiene 2008 24418 Stata Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** July $\boldsymbol{A}^{-\mathsf{M}}$ 10, Audrey Anita Syverson 2008 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. July 26, 1922 5, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□M 2₹X Months Mary land 218-74-1485 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Items 23e or 28e-f ehow eny injury or other traumatic event, the Medical Exart are must be notified and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1233 Green Holly Drive 21409 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3√√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOhn F. James Loversha B. Cantler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey A. Owens / Daughter 710 Fairway Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Gardens 7/14/2008 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Fugeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bic. /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death signed by the all d ba detached fo 5 Other (specify) 9 Unknown 9 I Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medicat examiner? 26. Place of Death (Check only one, 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No death 2 Accident 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after JTo the Funerel Dire 4 Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certific 7/10/2008 30. Name and address of person who completed cause of death (Item 23a) [Type, Print] MO How Are D Anne 31. Date filed (Month, Day, Year) Registrar's Signature State 1 4 2008 Registrar

DHMH 17 Rev 1/2001

Registrar

24420 State of Maryland / Department of Health and Mental Hygiene 2 () () 8 1 - For State Registrar Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 1255 PM **Physician** 2664 Showell 07 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WiComico NURSING & RELAB SALISBURY Anchorage If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months 1□M 28 F 222-28.9942 59 Yrs. Director Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County If Item 27 is marked other then "naturel", or Iteme 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at 1 MYes 2 No MD Salisbur Director Wicomico 10e. Street and Number 10g, Citizen of What Country? 51801 5.4 Square Completed by Funeral daath 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours aftar all Hygiana. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Black 3 Widowed 4 Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Office Management Elementary/Secondary (0-12) College (1-4or 5+) Secretary 13 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be file Dapartment of Haalth and Mantal Hy Importent: if Item 27 is marked oth Any injury or other traumatic event Be Madeline Showell Russell Baller Dillie ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DE 19975 Nicole Amwhite/daughter P.O. Box 875 Selbyville
20a. Method of Disposition Date

20b. Place of Disposition (Name of Date) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/08 Selbyville, DE Zoar Golden Acres 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
BENNIE SMITH 917WISAbella 21. Signature of Fundral Service Licens Salisbury, md 21801 FUNERAL HOME Approximate interval Between Onset and Death **Physician** 246015 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, beauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Disa to for as a nonsequence offad by the attending physician and datached for use as the burial-transit cartificata ba axecutad Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2 No 1 Yes 1 Yes After this cartification, principles Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation daath. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital o within 24 hours aft To the Funaral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who waln July 15/5 1051359 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST, SALISBURY, MJ 21804 1415 S-DIVISION DR- USHA NATISAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State		State o	f Marylar	nd / Depa	artment of F	lealth and I	Mental Hy	/giene	2008	244	21
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	/Medical Examiner		resulting in death)	•		(or as a consec								
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	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only	1 Certifying P	hysician: To the	e best of my kn	owledge, dea	th occurred at the ti	me, date and place	e, and due to th	ie cause(s	and manner as	stated.	
	thin 24	Medical	one) 29b. Signature and			ner stated.		29c. Licens				te signed (Month		
b	MIT BEER	-	>	Sparol	poman		M.D.		7660		7/1	4/08	,	
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Division or Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryla		rtificate of		rentai myt	Reg. No. 20	08	24422
Phys		1. Decedent's Name (First, Middle, La. Gopal Das Sh					2. Date of Dea Month July 1	Day	Year	3. Time of Death 12:51 p ^M
	dical niner	4a. Facilify Name (If not institution, give	· ·			r Location of Death		4c. County	of Death	
		508 Caldera Court 5. Social Security Number 6. S		s. last birthday)	West	ninster If Under 24 Hrs	8. Date of Birt	h	rroll 9. Birthp	lace (State or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	!	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2x No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify		etc. sian
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and 2 shoralth and No. 27 is ma		19a. Informant's Name/Relationship (Satish Shrestha,		19b. Mailii 508	ng Address <i>(Street</i> Caldera (and Number or Rui Court, We	ral Route Numbe stminste	er, City or Town, er, MD	State, Zip 21158	Code)
Pages 1 and of He Int: If Item		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval nom otate		osition (Name of matory or other place Cremato:	ry 7/16	Date /2008	20c. Location	eld,	MD
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₽ #	ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classics of Injury that initiated events	b. Due to (or as a cons	equence of):						
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w require been signatured should b	eted							Yes 2 No	3 Prot	
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sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 2	! ☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Dea	th (Check only o		har (Casai	
ng Phy ter this neral d	n: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	0 00	T I I I I I I I I I I I I I I I I I I I		how injury occu		<u>ly)</u>
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of injuny. A	t home, farm, st	M 1 □]Yes 2□No	28f. Location (City or To		ber or Run	al Route Number,
e Hospita 124 hours e Funeral letely filled	Medical C		nysician: To the best of my laminer: On the basis of examend and manner stated.							
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WIL		Platt! L	m	Manage 00 - 1 /mm	Pod	751924		July 16	,201	28
1+		30. Name and address of person who Herbert P. Humb.	erson Jr. MA		Wunchest	er RJ M	anches	te mo	211	102
	State istrar	31. Date filed (Month, Day, Year) JUL 1 6	32. Registrar's Si	gnature	San V.					
			LUVUI POLICIA	15						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 07:12 PM July 10, 2008 Marteal Stanton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing & Rehab Center Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Director 579-20-8353 Jan. 22, 1924 Washington, Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 25s-f show other treumstic event, the Medical Examinar must be notified at Director Maryland Prince George's Bowie 17 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3850 Enfield Chase Court 20716 United States deeth Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Race - American Black, White, etc. African filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify Specify: Completed by 3 √Widowed 4 □ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I peq Samuel L. Tyree Irene Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth a Gretchen S. Jones - Daughter 7702 Berry Place Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Depertment of He
Important: If iten
any injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park July 18, 2008 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Furneral Servide Lice 4001 Benning Road, NE Washington, DC 20019 23a. Part | Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Non-SMALL CELL 18 LUNG MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): ettending physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2□No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No hes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural Director: A death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel C completely filled 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33700 July 10, 2008 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 N. ARTIZAN WILLIAMSPORT, HOWE State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** $A^{\ M}$ Jean Elizabeth Sahl July 13, 2008 3:11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🕇 F Months Days Hours Pennsylvania Director 094-12-8817 07/22/1923 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h Counts 28a-f shov traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □No Maryland Montgomery Director Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 4925 Battery Lane Apartment 800 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items. 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 □Yes 2 ☑ No Specify. If Yes, Give Year or Dates Specify: White <u>≽</u> 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reno Pittenger ဂ္ Gertrude Sheriff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Betsy Davis / Daughter 713 Tenth St. Blackstone, VA 23824 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Arlington Nat. Cemet. 08/19/2008 1 Durial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Arlington, Virginia</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 10 Approximate Interval Between Onset and Death 23a. Part1. Enter the digrase, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair ire. List only one of use on each line. Immediate Cause (Final Ischemic Cardiomyopathy **Physician** 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23rl Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Partial Small Bowel Obstruction, Diabetes, Coronary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Artery Disease, Hyperlipidemia 24a Was an autopsy performed?

1 Yes 2 No certificate After this certification, funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 5 Pending investigation 1 X Natural To the roce.

within 24 hours after use.
To the Funeral Director: After the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the function by the function by the function by the funeral by the funeral by the function by the funct 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continer D0060117 July 13, 2008 10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park MD 8600 Old Georgetown Rd. Bethesda, MD 20814
31. Date filed (Month, Day, Year)
32. Degistrar's Signature State JUL 1 5 2008 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore.

Box 68760

Division of Vital

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State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan		artment			nd Me		giene Reg. No.	2000	0110	-
		П	Decedent's Name (First, Middle, Last	t)							2. Date of Dea	ath	7000	3. Time of Death	5
	Physicia Medic		SANDRA ELAINE SHO	ORE							JULY 5	Day 200		11:30 A	Λ
	Examin	-	4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	Death		4c.	County of Death		
	- 63. 		15107 Interlacher						er Spi		8. Date of Birt		Montg	omery place (State or Foreig	
	uneral irector		165-28-4542	BX ☐M 2 X F	7. Age (<i>In yr</i> s. <i>I</i>	-	Months	Days		Min.	(Month, Day 11/18/	y, Year)	Cou	ntry) PA	
and	۸		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation.			-				10d. Inside City Limit	s
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the	r 28a notif	Director	10e. Street and Number	501117			10f. Zip		TVCI	OPII		10g. Citiz	zen of What Cou	intry?	
th witl	23a o ıst be	al D	15107 Interlachen	Drive #	620			20	906				USA		
aryiand ZIZI3-VUSO should be filed within 72 hours after death with the Maryland nd Menral Hvolene.	Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed For 1 ☐ Yes	2X No	S. 13.				n? (Spec Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	, etc.	
2-0030	ıtural", o al Exan	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Giv Year or Da	e tes:	16a. Dece	1 ☐ Yes 2 edent's Usua	l Occupa	Specify:			16b. Kii	Specify: nd of Business/li	White	
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yla ould t	arkec atic	၉	Robert Bogatz			1					dsmith				
VICE 12 sh hand	7 Is m traum		19a. Informant's Name/Relationship (7) Andrew Shore - Son	,			•					-	r Town, State, Z		
1 and Healt	em 2	1	20a. Method of Disposition	-1	20b. P	lace of Disc	osition (Nam	ne of	- :		ate		aryland	21214 Town, State	
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Of VICAL DECORDS, P.O. BOX of Physician: The law requires that the death certif	To the Funeral Director: After this certificate has been signed by the attending ploompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②【☐ No 9 ☐ Unknown	1☐Live b	irth 2□Feta ant at time of d	l death 3	□Ectopic pr □ Other (sp						Month	Day Year	
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Ne de	s bee	olete	Chronic Obstructiv	e Pulmo	nary D	isease	<u>.</u>				24a. Was		24b. Were au	topsy findings availal	ole
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1) comea	w	NO		D	2454	3			Ju:	ly 14, 2	2008	
1>			30. Name and address of person who	completed caus	e of death (Iten										
			James A. Rossi, MI				orld B	lvd,	Silve	er S	pring,	Mary	yland 2	20906	
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Registrar	State of Maryla		artment of H			jiene	2008	24426	
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н	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. B. Date of Birtl (Month, Day June 4,	Year)	9. Birth	place (State or Foreign intry)	
			577-90-6290 Usuat Residence of Decedent	. 97				pune 4,	1910) G	eorgia	_
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. tnside City Limits	
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	라 다 or 26	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	intry?	
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	itan Itan	une		12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14	I. Race - Ameri Black, White		
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E	o deat	SICIS	in the past 12 months? 1 — Yes 2 No	4 Pregnant at time of]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year	
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_	certificete he		AC 111					1 Yes	2 No	death? 1 ☐ Yes	2 🗆 No	_
Vital		o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	ospital:	Tena	Othe		Death Check only or				_
ō	a Phys er this eral di	lon: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	1 30 DOX	4 NUISIN	g Home 5 Resid			ify)	_
0	ath. r: After e funer	atlo	1 ANaturat 5 Pending 2 Accident investigation	(Month, Day Year)	tnjury		(? Yes 2 ∐ No					
Division	or Attending Frater death, I Director: After din by the funers	Certificati	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and i	Number or Rui	ral Route Number,	_
ַ בֿ	rs after	Cer		building, etc. (Spec				City of Tow	n, State)			
	vithin 24 hours after deat within 24 hours after deat To the Funerel Director: completely filled in by the	edicai	Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge death	occurred at the two	e, date and pla	ace, and due to the o	ausu(s) a	nd mailiner as i	stated.	
,	within 2 To the complet		one) 29b. Signature and title of certifier	and manner stated.								
	8 4 % =		All and an an an an an an an an an an an an an	· n	2	29c. License			.au. Date:	signed (Month,	, yay, rear)	
		r	30. Name and a press of person who con	poleted cause of death (the	m 23a) (Time		10/1	55_	11	16/	08	_
T	n55		Fatima Y. Hussein,			•	ite 101	Camn Sn	rings	Manu	land 20746	
	Stat	te	31. Date filed (Month, Day, Year)	32 Redictrar's Sign	ature		ICC IUI	, vanip sp	111195	rid!'y	Tallu ZU/40	-
	Registra	ar	JOF T 9 5	2008 Mener	J. 1	barle						

			State of Maryland / Depa	rtment of Health and Me		
	-		RegIstrar 1. Decedent's Name (First, Middle, Last)		Reg. No 2. Date of Death	° 2008 3 2 1 1 2 7
	Physicia	an			Month Da	
	/Medic		Frances 1. 4a. Facilify Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	er	Snow Hill Nursing Home	Snow Hill		Worcester
- J	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	Birthplace (State or Foreign
	Director		218-12-1834 219-12-1834 1□ M 2∏F 86 Yrs.	Months Days Hours Min.	9-23-1921	
	pu. >		Usual Residence of Decedent 10c. City, Town or Loc 10a. State 10b. County 10c. City, Town or Loc	eation		10d, Inside City Limits
	faryla shov	5	,,,			1 ∐Yes 2X No
	the N 28a-1 notifii	Director	MD Wicomico Salisbu	11 Y 10f. Zip Code	10g. C	itizen of What Country?
	3a or	0	6429 Willing Drive	21801		USA
	ms 2	Funeral		Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
9	after or ite mine	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	i Tes, specify Cuban, Mexican, Fuencia I □ Yes 2XI No Specify:	ican, etc.	Black, White, etc. Specify: White
5-0036	nours ural", I Exa	d by	3 ☐ Widowed 4 💢 Divorced Year or Dates:		7.00	
<u>.</u>	"nati	lete	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of workin DO NOT use retired)	99	Kind of Business/Industry
Maryland 2121	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	llation Coordinat		Retail
ğ	other other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Surname)
<u>la</u>	uld be Jental rked c	TOB	Levin Nicholson	Nellie		Marshall
ar)	2 should b n and Menta ' is marked raumatic e	ľ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	g Address (Street and Number or Rura	l Route Number, City	or Town, State, Zip Code)
	es 1 and 2 should to Health and Meni (Item 27 is marked rother traumatic			Willing Drive, Sa		
0	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	natory or other place)	ate 20c.	Location - City or Town, State
altimore,	it. Pa rtmer rtant: njury			of Delmarva_7-15. Name and Address of Facility Box		
Ba	permit. Page Department of Important: If any injury or once.		Million March Black	ДО	unds Funer	
	-		23a. Parti. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only give cause on each line.	O5 E. Main Street, er the mode of dying, such as cardiac o		Approximate
	Physician		Immediate Cause (Final	«•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):			4-99.
	Examiner		Sequentially list conditions			
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (usease or injury that initiated events resulting in death) Last C			
8760,	be e) siclan buria	alE	545 to (6) as a solidoqualità si).			
687	ficate physis the	edical	d			
ŏ	leath certific attending p I for use as	N/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	7		23d. Date of delivery
Box	death e atte	Physician/Me	in the past 12 months? ILLIVE DIRTI 2 Li Fetal death 3L	Ectopic pregnancy Other (specify)		Month Day Year
о. О	at the by th	hys	9 Unknown			
<u>က်</u>	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown
000	requi	ted				
Records,	e law has b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	r: Th icate r, pag				1□ Yes 2,■	
Vital	'siclan: The law s certificate has l lirector, page 2 s	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	(Check only one)	a □0th (0(t-)
ō	ding Phys h. After this funeral dir	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how in	6 ☐Other (Specify) njury occurred
<u>o</u>	nding th. r: Afte e fun	ation	1, Month, Day Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division or	or Attendatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Ξ	ital ours after ral Di	Cer				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is		29a. Certifier (Check only (Check only a Check only (Check only (
	o the ithin 2 o the implei	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F > F 8		Justin	MD D54422	1	Tuly 13 2008
,	Snot		30. Name and address of person, who completed gause of death (Meny 23a) (Type,	Print)	0:	411,
_	J IVI		31. Date filed (Month, Day, Year) JUL 15 2008 JUL 15 4	Print) OKe, M.D. c	11851	
	Sta		31. Date filed (Month, Day, Year) 32. Signature	hacks)		-
	Regist	ar	JUL 1 5 2008 Stewn 15 19			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July July Year **Physician** 1805AM 2008 LYNN TATTERSALL SHERRI /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examine PRINCE GEORGE'S LANHAM DOCTORS COMMUNITY HOSPITAL 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖬 F 216-84-8789 Director 8/24/1967 Riverdale, MD 40 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County be filed within 72 hours after death with the Marylan ntal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at K∏Yes 2 No Directo Maryland Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9125 Kinzer Street Funeral 20706 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2√ No If Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Service Manager Private Important: If tem 27 is marked other unan up injury or other traumatic event. If once. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Byron Perry Tattersall Barbara J. Vaughan ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Vaughan / Mother 9125 Kinzer Street Lanham, Maryland 20706 Baltimore, 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department 07/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cem. Alexandria, Va. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease shock, or heart failure. e or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Onset and Death Immediate Cause (Final **Physician** lmonary we disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner advance Metastati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Ś signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 2 10 1 ☐Yes 2 ☐ No 1 ☐ Yes : After this certification of tuneral director, [25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 RF/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: d in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my professional and the cause of examiners and the cause of examiners and the cause of examiners and the cause of examiners and the cause of examiners and the cause of examiners and the cause of examiners and the cause of examiners are caused as a cause of examiners. Medical 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wish arrong 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 14300 Gallant Fox LN., Suite 222, BOWIE, MD. 20715 Kakesh Arora Date filed (Month, Day, JUL 1 5 2008 State Registrar

8

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Cassandra Denise Thompson 2008 7:00PM July 10, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice of the Chesapeake Anne Arundel Harwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Months Hours Min 1 □ M 2 🔽 F Director May 4, 1955 Washington, D.C. 577-74-4496 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince Georges Lapham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20706 9857 Good Luck Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or Itel 1 ₩ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hyglens Important: If Item 27 is marked other tha any Injury or other traumatic event, the 1000. the Program Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unk Luzenna Bragg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5213 Stoney Meadow Dr. Forestville, Md. 20747 Veronica Bragg / Daughter 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) July 18,2008 Clinton, Md. Resurrection 21. Signature of Funeral Service Lic 22. Name and Address of Facility Alexander S. 5538 Mariboro Pope / Pra Pikė/ Prorestville, Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 🔀 No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No ours after death. death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours aff To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 11, 2008 31. Date filed (Month, Day, State JUL 1 5 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Tackish Billie Jo 2:52 P July 11, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year) March 27, 1933 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 😿 F 75 Director 223-40-1596 Virginia Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" or Items 23a or 28a-1 show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 KNo Forestville 5 control of the control Director Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20747 #101 5052 Silver Hill Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√x No Specify: White δ 3XXWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any Injury or other traumatic contracts. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McGruder Stowers Margaret William Kent Compton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18877 Old Valley Pike Woodstock, Virginia Bonnie Smith / Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XX remation 3 ☐ Removal from State July 19,2008 Edgewater, Maryland Kalas Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral 80 vice License 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 10 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, noch, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se's consequence of HYPERLIPIDEMIA burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? has To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director After this certified 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: XX Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifiers 29c. License number 29d. Date signed (Month, Day, Year) 7/14/2008 D0028936 30. Name and andress of person what completed cause of death (Item 23a) (Type, Print) MD 20706 Michael Joly 7241 Hanover Parkway - Suite A. Greenbelt, MD 31. Date filed (Month, Day, Year)
JUL 1 5 2008 32. Registrar's Signature State

Registrar

			For State	State	of Maryla	nd / Depa	artment o			ental Hyg	giene	2008	24431
			Registrar 1. Decedent's Name (First, Middle	e. Last)			incate	- Deat		2. Date of Dea			3. Time of Death
	Physicia		Laurie Nina Vinson							July 14, 2008			9:55 PM
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or Location of Death			<u> </u>		County of Death	
	6633 Grouse Road					Elkridge				Howard			
-b	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Y	_		8. Date of Birti (Month, Day	v Year)	9. Birthp	alace (State or Foreign
	Director		220-14-2373	1□M 2X1F		86 Yrs.	morning D	ayo Hour		pr 8,	19	22 Mary	Land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation					11	0d. Inside City Limits
	f sho	ō	1										1 ∐Yes 2 🛣 vo
	the 28a-	rect	MD Howa: 10e. Street and Number	ra	£1.	kridge	10f. Zip Co	de			10g. Citi	izen of What Cour	ntry?
	3a or	i Di	6633 Grouse	Road			2107	5			USA		
	deatl	ner	11. Marital Status		cedent Ever in	U.S. 13.	Was Deceden If Yes, specify	of Hispanic	Origin? (Spec	cify Yes or No-	.	14. Race - Americ Black, White,	
õ	or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Marr		2 X No		1 ☐ Yes 2 X			110011, 010.,			
212-003p	hours ural";	q p	3 Widowed 4 □ Divorced	Year or I	Dates:	16a Dasa	dont's Havel O				10h V	WILL	
Ç	n 72 l "nat edica	Completed	15. Deceden (Specify only highe	st grade completed,		(Give	dent's Usual C kind of work of DO NOT use r	ccupation one during n etired)	nost of workin	ng	160. KI	ind of Business/In	dustry
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2	illed I Hyg other	Be C	17. Father's Name (First, Middle,	Last)				18. Mc	other's Name	(First, Middle,	Maiden	Surname)	
/land	Aenta Aenta rked tic ev	ToB	Solomon G. Le	each				Nin	na L.	Bunty	n		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations									or Town, State, Zip	
Ę,	and sealth n 27		Vicki Strain	/daugnte								D 21075	
2	ges 1 t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 XCremation	3 □Removal from		Place of Dispo cemetery, cre			:	ate		ocation - City or To	
Dallillor	t. Partmen tant:		4 ☐ Donation 5 ☐ Other (S	pecify)	C							ltsvill	
ם מ	permi Depar Impo any Ir		21. Signature of Funeral Service	Licensee	<i>;</i> -	Ğ	oing Ho	me Cre	ematio	n Servi	.ce	P.O. Box	x 784
			23a. Part1. Enter the sease, or shock, or heart failure. List	complications that	caused the de	1251 B	everly ter the mode o	L. Hed	ckrotte n as cardiac o	r respiratory ar	CLa	arksville	Approximate
	Physician		Immediate Cause (Final		each line. Static I			,		. ,	,		Interval Between Onset and Death 10 years
	/Medical		disease or condition resulting in death)	a	o (or as a conse		caricer					-	TO YEARS
	Examiner -		On a constant of the second state of the secon										
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	equence of):									
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	/25 22 2 2222	onument of							
0,00,	be ex cian a	E	Tooling in deality Last	Due to	o (or as a conse	equence or):							
ò	physicate sthe	dical		d						-			
YO O	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf preg	nancy						23d. Date of deliv	erv
ă	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	in the past 12 months?	4□Preg	birth 2□Fe gnant at time of		⊒Ectopic pregr ⊒ Other <i>(speci</i>					Month	Day Year
9	t the by the	hys	9 ☐ Unknown	9□Unki	nown								
r n	ss tha	by P	Part II. Other significant condition	9		esulting in the u	nderlying caus	e given in Pa	art I.	23e. Did to	obacco i	use contribute to t	he cause of death?
colos,	equir en si ould I	led	Chronic Atrial	nic Atrial Fibrillation 1 Yes						Yes 2	2 No 3 Probably 4 Unknown		
נו	law ras be	Completed								24a. Was autor	psy	prior to co	opsy findings available ompletion of cause of
=	The	Con								perfo	ormed? 2. ∑ No	death? 1 ☐ Yes	2 No
3	ician: Sertific ector,	Be (25. Was case referred to medica examiner?						lace of Death	(Check only o	one)		
Division of vital neconds, r.O. Box 660,	Phys this aldir	P.	1 ☐ Yes 2 ☐ No 27. Manner of Death		Inpatient 2	ER/Outpatie						6 Other (Speci	fy)
	ding J. After funer	ion	1 XNatural 5 ☐ Pendin	g (Moi	nth, Day Year)		M 200.	Injury at Work? 1 ☐ Yes 2		28d. Describe I	riow iriju	ry occurred	
0	*Attending Physician: The lav sr death. rector: After this certificate has by the funeral director, page 2 !	fica	3 Suicide 6 Could	not be 28e. Plac	e of injury - At	home, farm, st				28f. Location (Street ar	nd Number or Rur	al Route Number,
5	al or after il Dire	Certification:	4 ☐ Homicide determ	build	ding, etc. (Spe	city)				City or To	wn, State	e)	
	ospit hours unera			ng Physician: To the Examiner: On the									
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	one)	and mai	nner stated.								
	To Too	2	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)		
			1 sun 1/	1100	11/	- 06 \ -		-100	1		Jul	y 15, 20	08
(\$	200		30. Name and address of person Bruce R. McCurd				-	e Sui	te 101	Baltin	nore	. MD 212	28
Ĭ	Sta		31. Date filed (Month, Day, Year)		Registrar's Sig				30 101			,	
	Registr	ar	.1111 7	ь 2008	190000	H	A W						

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of H rtificate of I			giene leg. No. 2	008	24432	
=(1	Physici	an	1. Decedent's Name (First, Middle, Last Pilar	В.	Ve	uichn		2. Date of Dea July 13,	ath Day	Year	3. Time of Death 2:21 A M	
190	/Medio		4a. Facility Name (If not institution, give		- V C	Vaughn 4b. City, Town, or Location of Death		July 13,		Ic. County of Death		
	Funeral Director	1	Futurecare Pineview Nu							Prince George's		
4			300-92-7431		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 10/16/19	2 ^{Year)}	9. Birthp Cour Phi 1	place (State or Foreign htry) ippines	
	yland low at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits	
	e Mar Sa-f sh tiffed	Director	Maryland Prince Geor	ge	Temple Hill	s					1 □ Yes 24 No	
	ath with the 23a or 29 ust be no	ral Dire	10e. Street and Number 6001 Fisher Road			10f. Zip Code 2074			U	of What Cour SA		
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 AN If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White, ecify: Fil:	etc.	
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad	+) 16a. Dece (Give life.	ing	16b. Kind of Business/Industry						
d 21		To Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle,	(First, Middle, Maiden Surname)						
/lan			Cornelius E. Vaughn				Diosdada	Santiago	Barre	do		
Maryland		ľ	19a. Informant's Name/Relationship (7) Maryann V. Yacat/Daugh		ŀ		and Number or Rur		er, City or To	wn, State, Zip	Code)	
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🕅 4 □ Donation 5 □ Other (Specify,		20b. Place of Dispo cemetery, cre Forest Law		ce) 7/17/2	Date 2008 H		on - City or To		
Balt			21. Signature of Funeral Service Licen	ee .			ss of Facility Geo Lill Road Ox					
	Physician /Medical Examiner		23a. P. 1. Enter the discrete final see, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one (at e on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Scalar Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
	ysician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as a	a consequence of):							
68760,			that initiated events resulting in death) Last	Due to (or as a	a consequence of);							
687		edical	•	d								
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delive		rery Day Year	
		by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in					n in Part I. 23e. Did tobacco			use contribute to the cause of death?	
ord									1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unkr			
or Vital Records,		Completed						24a. Was autop perfo 1∐ Yes	an 2- osy ormed? 2 XXX o	death?	opsy findings available ompletion of cause of 2 No	
Vit	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	-1 0FFD/0-1-1-	at at pos Oth	DOT:	ace of Death <i>(Check only one)</i> Nursing Home 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>				
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	n: To	27. Manner of Death	28a. Date of Injur	ry 28b. Time o	III 3 DOA	4.K.Nursing H	ome 5 ∐ Resi 28d. Describe I		1,	ify)	
sior		atio	XX Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Injury		Yes 2 No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		Medical	29a. Certifier 1 ★ Certifying Phy (Check only one)	rsiclan: To the best of iner: On the basis of and manner sta	of my knowledge, dea i examination and/or i ited.	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)	
	Within 10 mo	Σ	29b. Signature and title of certifier			29c. Licens	se number 54	5	29d. Date si	gned (Month	11 2000	
	03		30 Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	Print)	CENTER	WARD	OUF,	ud.	7, cos 20602	
	Sta Registi		JUL 1 5 2008	32. Registra	ar's Signature				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** 07 23 08 0430 DORIS WHITT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS BRADDOCK CAMPUS CUMBERLAND Birthplace (State or Foreign County) 8. Date of Birth May 23, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 ☐ M 2 ☐ F 75 220-28-9804 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23e or 28a-f show with Injury or other traumatic event, it is Madical Exprision 1. ust be notified at once. Frostburg X☐Yes 2☐No MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21532 100 Honeysuckle Ln. Apt. 112 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Corrigan Yeider Marshall Timothy Yeider ပ 19b. Mailing Address (Street and Number of Rural Route Number, City, or Town, State Zocode) 14235 Elton Dr. SW Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print)
Linda Piercy niece 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Sylvania Hills Memorial Park PA 1 Burial 2 Cremation 3 Removal from State 7/26/2008 Rochester 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Linense 22. Name Sed Adem Purellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause do each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2.2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month. Day.

9 2

29c. License number 00066070 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

SETON DR. CUMBBRUAND, MD 32. Refi

P ☐ Octallying Financian. To the best of the kind decided and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 РΜ July 8:10 Elvin Frank Wagner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Ginger Cove Health Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months Yrs. Oct. 1920 Pennsylvania 4. 182-16-5753 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐Yes 2 ☐No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 United States 4000 River Crescent Drive 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1.∏Yes 2√√No If Yes, Give Year or Dates: 1 Never Married Married 2□No XX Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Catholic Church Buisness Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Schenck Harry A. Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3529 Devon Drive Falls Church Virginia 22042 Carol Taylor / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2008 St. Mary's Cemetery Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. of Funeral Service 147 Duke of Gloucester St. Annapolis, MD 21401 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosc 1-Parl disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due o (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 26. Place of Death (Check only one

Physician /Medical Examiner and

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>م</u>

Completed

Be

၉

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner count be netfiled at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Examine Physician/Medical þ Completed Be ၉ Certification:

burial-tran the attending physician the as for use signed by t I be detach has been page 2 s certificate After this of funeral din

or Attending Physician: The law requires that the death certificate be executed death. d in by the f thin 24 hours after do the Funeral Direct ompletely filled in by filled in by Hospital To the within 2

Medical State

25. Was case referred to medical examiner? 1∐Yes 2⊅No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

and manner stated 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

2 🗆 No

28c. Injury at Work?

1 ☐ Yes

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Pedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, 4300 Gallant Fox Lane Ste 222 Bowie MD MD

31. Date filed (Month, Day, Year) **JUL 1 4 2008**

6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death ø 1. Decedent's Name (First, Middle, Last) Day IŌ 2008 M. Wharter Anna JULY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. DICOMICO Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sex 1 □ M 2 🗹 F Months Days Hours 217-28-4207 2/12/1932 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MD Girdletree Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21820 Taylors Landino.

12. Was Decedent Ever in U.9.

Armed Forces?

1 | Yes 2 | No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaller House 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Mamie Taylor Teagle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5904 Taylors Landing Rd. Birdletree MD 21829 50n Kenneth Wharton Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Snow Hill, MD 7/17/08 4 ☐ Donation 5 ☐ Other (Specify) Mt. Wesley Cemetery 22. Name and Address of Facility 917.W. Isabollast. 21. Signature of Funeral Service Licensee Bennie Smith Fune salthane Saltsbury, ND 21801 04 MALL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SCVD YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

Funeral

Completed

æ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Express.

Baltimore, Maryland 21215-0036

Examine

attending physician for use as the the detached signed by t d be detach

Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Be

burial-transi

completely within 2. the State

certificate be execu P.O. Box 68760 Records, verai urector: After this certificate has been sittled in by the funeral director, page 2 should. Division of Vital Hospital or Attending 24 hours after death Funeral Director:

Certification: To 2 Accident 3 Suicide 4 Homicide 29a, Certifier Medical (Check only

29b. Signature and title of certifier

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

1 Yes 2 No

27. Manner of Death

1 Natural

Hospital:

5 Pending investigation

6 ☐ Could not be

M.D. Ph.O.

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

29c. License number

28c. Injury at Work?

1 □Yes 2 □ No

3 D Ectopic pregnancy

5 Other (specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed Yes 212

1 □ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARROLL St. SALISBURY Md SWIERKOSZ MD 10MASZ

2008

31. Date filed (Month, Day, Year) JUL 14

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

28a. Date of Injury (Month, Day, Year)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1315 M **Physician** Pauline Whaley 2008 Melva /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 81 213-24-0551 North Carolina 4/10/1927 Director Usual Residence of Decedent 10d, Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at 1 X Yes 2 ☐ No Funeral Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 7906 Dublin Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 **Y**No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. Be Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) medical bookkeeper 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Hunter James Albert McKelvey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7906 Dublin Rd., Salisbury, MD 21801 Paula Donovan/daughter 20b. Place of Disposition (Name of Springhill memory) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 7/15/08 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd, Salisbury, MD 21804 RKeller CA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20 WS **Physician** ANOXI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 2 Ne 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 100 E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -reu 31. Date filed (Month, Day, State 2008 15 .3731

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 13 per fh 9881 7-29-08 yt State of Maryland? Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month __ Physician D. Wise Donald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEdical SALISBURY Dicomico Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/13/1957 6. Sex 7. Age (In yrs. last birthday 5. Social Security Number Hours Months Days 1**∑** M 2□ F 50 Pennsylvania 173-52-2128 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 K Yes 2 □ No Director Chambersburg Pennsylvania Franklin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17202 1010 Willowbrook Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married WYes 2 No Specify: Specify white **∂** 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) beverage distributor truck driver 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara J. Staley Robert M. Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1010 Willowbrook Dr., Chambersburg, PA 17202 Jane Brown Wise/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/17/08 4 ☐ Donation 5 ☐ Other (Specify) Chambersburg, PA Norland Cemetery ²². Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Saliasbury, MD 21804 21. Signature of Funeral Service Nicensee Kete R Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AXUD disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 11**2** Yes 2 ☐ No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

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Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

Smyde 31. Date filed (Month, Day, Year) JUL 15

29b. Signature and title of

30. Name and address of

D.O. 1)me egistrar's Signatur

who completed cause of death (Item 23a) (Type, Print)

100 E (arroll)t.

29c. License number

H5049)

29d. Date signed (Month, Day, Year)

7/12/08

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward M. White Jr. July 14 2008 4:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours 215-03-6818 Director 8/16/1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Blue Heron Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: Army 1 ☐ Never Married 2 Married "natural", or White Edward M. JR. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the office interior designer Maryland Office Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Edward M. White Sr. Emma Kreiling traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (/2 item 27 ls other tra Sue Ann Bell/daughter 3 Blue Heron Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 7/16/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Kith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Corr /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown n signed by to ld be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? (es DNo 1□ Yes 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 257 No. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P this 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours at To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M

State Registrar Villelor

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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	Physicia /Medic		1 - State Registrar 1. Decedent's Name (First, Middle Jimmy Michae		llia	ams	Cer	tificat	e of L	Jeath		2. Date of Do Month July	eath	20	0.8 /ear	3. Time of Death 19:11 P M
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im.	Funeral Director		5. Social Security Number 577–80–1917	6. Sex 1 M 2 ☐ F		(In yrs. last bir 50	rthday). Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 01/01/	irth 1958 1958	r) N	9. Birthp Coun Iorth	ace (State or Foreign try) Carolina
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/land 2	uld be filed Mental Hyg Irked other Itic event, 1	To Be C	17. Father's Name (First, Middle, Charles Williams									(First, Middl	e, Maide	en Surname)	
Mar	s 1 and 2 should be f Health and Menta item 27 Is marked other traumatic ev		19a. Informant's Name/Relations Kenneth L. Willia			5	024	Šilver	Hill	Court	#104	al Route Num	ict H	gts, M	20	747
saitimore,	permit. Pages 1: Department of He Important: If iten any Injury or oth		20a. Method of Disposition 1	Specify)	n State	20b. Place o cemete	eake	Creme	itory		07/17	7/2008	Bel	tsville	e, Mai	
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VII	Physiclan: this certifical ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Lionnital:	1 Inpatie	nt 2 ER/O	utpatier	nt 3 🗆 D	OA Oth	er.		th <i>(Check onl)</i> ome 5□ Re		6 ∏Othe	er (Spec	f(v)
Sion or	ling After fune	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident invest	28a. Date (Mo		ry 28b.	Time o Injury		28c. Injur Wor	y at		28d. Describ				
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could detern	ninod 200. I lat	ce of inju ding, etc	iry - At home, fa c. (Specify)	arm, str	eet, facto	ry, office				(Street Fown, St		er or Rui	al Route Number,
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	الله الله		30. Name and address of person Michael Fras	er. 7503	3 50	urratte			Llint	m	MD	207	35			
	Sta	te	31. Date filed (Month, Day, Year	32.	Registra	ar's Signature	60			,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 24440 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13°, July 2008 6:25A. M **Physician** Wynkoop, Jr. Henry N. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 10, 1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours 80 Washington,DC 578-30-3889 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Widged Examination to the property once. 1 Wes 2 □ No Maryland | Prince George's Greenbelt Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20770 15 R Laurel Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: WWII Specify Specify: Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Police Elementary/Secondary (0-12) College (1-4or 5+) Department Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth L. Krueger Henry N. Wynkoop, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44 B Ridge Road Greenbelt, Maryland Nancy L. Remenick -daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Metropolitan Crematory 7/16/2008 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Liver Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Myocardial Infarction attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a 1 Tyes 2 TNo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2XNo 24a Was an autopsy performed? 1 Yes 2 XNo has e 2 s his certificate ha 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 23125 July 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 1 5 2008

Madhu K. Mohan, M.D. 6502 Kenilworth Avenue, #100 Riverdale, Maryland 20737

326Registrar's Signature

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		_	State Registrar			Cer	tificate of	Death			Reg. No.	20	08		+41
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arylan show		_	10a. State 10b. County			Town or Loc							10	od. Inside City L 1 ⊠ res 2 [
the M 28a-f		Funeral Director	MD Montg	omery	К	OCKV.	10f. Zip Code	<u>-</u>			10g. Citiz	en of Wh	at Count		
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r deat lems		nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. V	Vas Decedent of H		n? (Specit Puerto Ric	fy Yes or No	. 1		America White, e	an Indian, tc.	
Is after		D.	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1	∐Yes 2. XXNo	Specify:				Specify:	As	ian	
ING 21215-UU36 be filed within 72 hours after death with the Maryland hall Hygiene. de other than "natural", or items 23a or 28a-f show event. The Modical Examinar must be nutting at		ted	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occup	oation	of unchina		16b. Kin	d of Busi	ness/Ind	ustry	
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D D D			6th 17. Father's Name (First, Middle, La	st)		MCI	Jiidii C	18. Mother's	s Name (/	First, Middle,					
Yland ould be file I Mental H arked oth		o Re	Minglai Y	eh					Chen	ai Y	/eh				
Maryla Id 2 should Ith and Men 27 is marke	ľ		19a. Informant's Name/Relationship				g Address (Street								
F Hear		-	Yuchu Yeh - D 20a. Method of Disposition	aughter			7 Briar		Ra R					wn, State	
Pages nent of ant: If ite			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Denation 5 ☐ Other (Spe		V /		sition (Name of natory or other pla	i	/11/		Han		•		
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n ಷಿಪಿ ತ ಕ	9	+	Celler !	L Xnd	L	1 2	246 N. I	Washir	ngto	n St	Roc.			MD208	
			a. Part 1. Enter the disse, or conshock, or heart force. List or Immediate Cause (Final	ly one cause on each line.										Approximate Interval Betwee Onset and Dea	
Physicia /Medic	_		disease or condition resulting in death)	a. ATHEOS C			CARDIO	VASUL	AR D	DISEAS	SE				
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ted lisit		June	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a											
execur n and ial-trar		Examiner	that initiated events resulting in death) Last	c. LUMBAR Due to (or as a											
OI VILAI RECORDS, P.O. BOX 08/00, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit		Ca		d											
box box box leath certifical attending photon is attending photon in the box box box box box box box box box box			IF FEMALE:	20- 16							1				-
box death cer attendir for use		Pnysician/med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal o	death 3	Ectopic pregnand Other (specify)	су			2	3d. Date Mont		ery Day Yea	ar
t the c by the tached	3	nysı	1 □Yes 2 □No 9 □ Unknown	9 🗌 Unknown											
ding Physician: The law requires that the de h. After this certificate has been signed by the Attenthal director, page 2 should be detached		2	Part II. Other significant condition	contributing to death but	not result	ing in the ur	nderlying cause gi	ven in Part I.						ne cause of dea	
aw requires t as been signe 2 should be c		ered												ably 4 ☐ Unk	
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VILAI Iclan: T sertifical ector, pa	0	S	25. Was case referred to medical					26. Place o	of Death (1 □ Yes Check only o		11	□Yes	2 X 10	
Physic Physic this ce		2	examiner? 1 ☐ Yes 2 ☐ No	Hospital:			I 3 L DOA			e 5 ☐ Resi				y)	
ding P h. After funer			27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day,	Year)	28b. Time of Injury	Wo	iryat rk?]Yes 2 ∐No		3d. Describe	how injury	occurre	d		
or Attencate death Director:	. 3	Certification:	3 Suicide 6 Could no determine	be lace of Injury	y - At hom (Specify)	ne, farm, str				If. Location (r or Rura	al Route Numbe	∍ <i>r</i> ,
ital or urs afte ral Dir	3	Sel							JA						
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	. 1	edicai	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of e and manner state	examination	ledge, deatl on and/or in	n occurred at the t vestigation, in my	ime, date and opinion, death	i place, ar h occurred	nd due to the d at the time,	cause(s) date and	and mar place, a	nner as s nd due to	tated. the cause(s)	
To the within To the	. 2	Med	29b. Signature and title of certifier	~ ~			29c. Licen	se number			29d. Dat	e signed	(Month,	Day, Year)	
ス			1 Mind	200h.			D41	162			Ju	ly	10,	2008	
			30. Name and address of person wi	•	,				1		200	7 4			
	State		Vinu Ganti, 31. Date filed (Month, Day, Year)	MD 19529 I	Joct 's Signatu	ors	urive G	erman	towr	n ,MD	208	/4			
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State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death

24442

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its. Modical Examination is a confined at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		Registrar					OC.	imoa		Jour.			ieg. No	J			
siciar		1. Decedent's Name Alice O		e, Last) nderson								2. Date of Dea June	th 225	3 ^y 2	2 00 8	3. Time o	f Death Рм
edica mine		4a. Facility Name (I	f not institutio		number)				Town, or	r Location	of Death		40		y of Death rford		
ral		5. Social Security N 212-18-9	lumber	6. Sex 1 ☐ M 2 📆		e (In yrs. i	ast birthday) Yrs.	If Unde Months	or 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da) May 9,	h y, <i>Year</i> 192) ! 1	Cou	place (State intry) yland	or Foreign
	ŀ	Usual Residence of							L	L		1107)	172		IIGI	y rana	
6	ł	10a. State	10b. County			10c. City	y, Town or Lo	cation		_						10d. Inside C	City Limits
1	2	MD	На	rford			Stre	et								1 □Yes	No No
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5	<u> </u>	2025 Jer	ry Roa	.d						2115	4			Į	JSA		
	2	11. Marital Status		12. Was I	Decedent	Ever in U.	S. 13.	Vas Dece	edent of H	lispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)			ce - Amer	ican Indian,	
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á	2	John Iv										Katherin					
F	-	19a. Informant's Na					19b. Mailir	ng Addres	s (Street			al Route Number				ip Code)	
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	Ì	20a. Method of Disp				20b. P	lace of Dispo emetery, crei	sition (Na	ame of	- 1		Date	20c. l	Location	- City or T	rown, State	
		1 ∐ Burial 2 L 4 X Donation		3 ☐ Removal fr Specify)	om State		<i>,,</i>	,									
once.		21. Signature of Fu	ineral Service	Licensee de,	Dire	ctor				_		d 655 W	. Ва	alti	more	Stree	t
	1	23a. Part 1 Enter th	he disease, o	complications th	at caused	the death	n. Do not en	alt1 er the mo	more ade of dyir	ng, such a	2121 as cardiac	or respiratory a	rrest,			Approxima Interval Be	ate
an		shock, or hea Immediate Cause	ırt failure. List (Final	only one cause	on each li	ne.										Onset and	d Death
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1.5	animedical			d													
/W/C		IF FEMALE: 23b. Was decedent	t prognant	23c. If yes,										23d. D	ate of deli	ivery	
		in the past 12	months?	4 □ F	regnant a	2 □ Feta at time of d	I death 3[leath 5[☐ Ectopic ☐ Other (У					Nonth	Day	Year
Completed by Dhysic	2	9 ☐ Unknown	- INO	9 □ ∪	Jnknown												
2	<u> </u>	Part II. Other signif	ficant conditi	ons contributing	to death b	ut not resi	ulting in the u	nderlying	cause giv	en in Par	t I.	23e. Did t	obacco	use co	ntribute to	the cause of	f death?
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8	5											auto perfo	rmed?		death?	2 No	1 00000 01
0	ע ו	25. Was case refer	red to medica	ı			-			26. Pla	ce of Deat	th (Check only o					
		examiner? 1 ☐ Yes 2 ☐	Mo	Hospital:	I ☐ Inpatio	ent 2	ER/Outpatie	nt 3 🗆 🛭	OOA Oth	ner: 4 🔀 ا	Nursing H	ome 5 🗆 Resi	dence	6 □ ○	ther (Spe	cify)	
į	=	27. Manner of Deat	h 5 ∐ Pendii	28a. D	ate of Inju Month, Da	ıry ıy, Year)	28b. Time of Injury		28c. Inju Wor			28d. Describe	how in	jury occu	urred		
1	Call	2 ☐ Accident 3 ☐ Suicide	investi 6	gation not be				М		Yes 2[□No						
1		4 ☐ Homicide	deterr	ninga 200, F	lace of Inj uilding, et	ury - At ho c. <i>(Specif</i>	ome, farm, st y)	eet, facto	ry, office			28f. Location (City or To	Street wn, Sta	and Nun ate)	nber or Ru	ural Route Ni	umber,
Modical Cartification. To	2	29a. Certifier (Check only	1 Certifyi	ng Physiclan: To Examiner: On t	the best	of my kno	wledge, deat	h occurre	ed at the ti	ime, date	and place	, and due to the	cause	e(s) and	manner as	s stated.	B(S)
1	בַּבַּ	one)		and r	manner st		on and/or II					ou at the time,					
2	2	29b. Signature and	title of certifie	X/ne	1.4.	4 /	1/1			se numbe						h, Day, Year)	
		1 lun	au	OVUM	w	N	N)		10	026	318			0+	-14	-08	
		30. Name and addr			cause of c	death (Iten	n 23a) (Type,	Print)	1.11	4.0-	()	Drive		11 -		10. H.	1 7 100
State		31. Date filed (Mon		romis,	Registr	ar's Signa	ture	74 H	711 (vrp	Lnn	Will	/	1461	ngar	n w	1. 4100
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Registrar

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B Thendall R-aullius D 25643 07/26/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thendall R Faulling mD/555 W. Towartown Blud/Bolto MD 21204	To th withir comp	Me		-41	29c. License number	:		
Of Data Stad (Africk D. V.)	24				1 25643	3	07/26/	3008
Of Data Stad (March Day VI)	2		Wendall R Facelknerm			Blud/I	SectoMi	21204
H 17 Rev 1/2001			31. Date filed (Month, Day, Year) 32. Registral	's Signature				
	VIH 17 Rev 1/20	01	J. Krister	1 Com	ed .			

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 2008 Month Year **Physician** 29, 8:00 A M Mary E. Agnello Ju1y /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Nursing Timon ium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX Months 220-14-9248 92 **Director** Feb. 9, 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Wedical Evanities is used by notified at 1 ☐ Yes 2X XVo Director MD Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21030 9 Dellwood Ct. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 及风No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes X2X No Specify: XX Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, I'm Medic one. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Engle Cora Finnegan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Hofmeister / Niece Dellwood Ct. Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 7/31/08 Druid Ridge Cemetery Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Licenses 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. Calme m 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months2 3 Ectopic pregnancy 5 Other (specify) Ö 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Vital 1 □Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after deatl 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature age 7.29-08 166€ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 EDDIE NAKHUDA, M.D. 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

MARY AGNELLO

State of Maryland / Department of Health and Mental Hygiene 24446 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** ^{Day} 2008 July 23, 1:45 AM M William Kenneth Bunce /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Heron Point Nursing Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) 5. Social Security Number 9. Birthplace (State or Foreign Country)
Ohio 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days Director 577-60-2898 100 Aug 31, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits MD 1 ☐ Yes 2¶ No Kent Director Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. Campus Avenue 21620 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ۾ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 4 Elementary/Secondary (0-12) 12 educator education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elma Ellen Coughenour Thurman Daniel Bunce ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Duvall/daughter P.O. Box 1079 Allen, MD 21810 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street m Enter the dis s Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disase, or complications, or heart failure. List only one cause Approximate Interval Between Onset and Death 23a Part Immediate Sause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as nse IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) DO060301 7/23/08 REURI STES CHESTERTAIN, NO eted cause of death (Item 23a) (Type, Print HMEN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 0 Registrar

Robert Anthony Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05276 2008 24447 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month July 9, 2008 Dav 1210 hrs Medical Examiner Robert Anthony Brown 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1523 Hazel Street Apt. #4 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 1111)k 5. Social Security Number ink 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Country) Director 1X M 2 F 55 Yrs 29 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore 28a-f show MD notified at once. Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number USA 21215 4615 Park Heights Avenue "natural", or items 23a 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? unk 1 Never Married 2 Married Yes No black 2 X No specify: Specify. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in injury or other traumatic event, Yes Divorced If Yes. Give Year ≥ 16a. Decedent's Usual Occupation (Give kind of work doneink 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) unk MD 21215-0036 unk 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Sig Mure Funeral Service Lin that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or complications **Physician** Between Onset and re. List only one cause on each line Death /Medical Cirrhosis of liver Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed AMENDED 23a, PII, 27, perME, g882 8/7/08 TT Physician/Medical X UNPENDED the attending physician led for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the I be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown \$ Endocarditis Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? certificate has page 2 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Other; examiner? Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 1 V Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 10, 2008 O.C.M.E.

Registral

OCME 2006

State

OCME

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** John C. Brooks /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cambrida General Dorchester If Under 1 Year | If Under 24 His. 8. Date of Birth (Month, Day, Year) Aug 5, 191 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1**∑**M 2□F 214-07-9658 95 1912 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is merked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1300 Hambrooks Blvd 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: ⋧ 3 Widowed 4 Divorced Completed un 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) businessman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glesner Neild Brooks Hattie Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Brooks/son 107 Shawnee Circle Cambridge, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si nature Funera Servic License KONA I d S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 25a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2♣No 24a. Was an certificate has autopsy 1 Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anapatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this ithin 24 hours after death.

o the Funeral Director: A er thi furieral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 6 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 (Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Mgnth, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar EWMIE

2. Registrar's Signature

			For State Registrar		State of	Marylan		artment rtificate				ental Hy	gien Reg. N	000	3 24449
	Physici	an	1. Decedent's Name		Last)						-	2. Date of D Month		Day Year 2008	3. Time of Death
	/Medio Examir	cal	John M. 4a. Facility Name (If I	not institution,	=	per)		4b. City,	Town, or			July 1	-	c. County of Deat	
	Funeral		5. Social Security Nu		S. Sex 7	Age (In yrs.	last birthday,	If Under	1 Year	If Under	24 Hrs. 8	B. Date of Bi	irth		hplace (State or Foreign
	Director		220-09-25		1 ∑ M 2□F	90	Yrs.	Months	Days	Hours	Min.	$\frac{1}{1}$	19	18 Mar	yland
	/land		Usual Residence of I	10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
	a-fsh	ctor	MD				Balti:	nore							1 Yes 2 □ No
	th with the 23a or 28	al Director	10e. Street and Numl 830 W. 4		reet #764			10f. Zip		1211			10g. (Citizen of What Co USA	untry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it indicate. Expring rount by coffic d at once.	d by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		If Voc Cive	es? □No		Was Decedif Yes, spec		ispanic Or n, Mexica Specify		ify Yes or N ican, etc.)	0-	14. Race - Ame Black, White Specify: Ma	e, etc.
15-0	"natu	Completed	(Specif	15. Decedent's y only highest	Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation Juring mos	st of working	7	16b.	Kind of Business/	Industry
212	within liene.	omp	Elementary/Second	dary (0-12)	College (1-4	or 5+)		lustri					f1e	et car 1	easino
g	e filed al Hyg I other vent,	Be C	17. Father's Name (F		ist)							First, Middle		en Surname)	Cabing
ylaı	ould b Ment larked latic e	To E	B. Frank							Mar	y Leve	ering			
Mar	d 2 sh th and 7 is m traum	i di	19a. Informant's Nan	'	ckey/daug	htor	T.	ng Address W. Ti						y or Town, State, 2	
<u>ē</u>	f Heal f Heal item 2 other		20a. Method of Dispo		ckey/ daug	20b. P	lace of Disp	osition (Nam	ne of		Da	Cimoni _{te}	_	MD 210 Location - City or	
altimore,	Page: Iment o Iant: If	190	4 X Donation 5	Other (Spe		ate	emetery, cre	matory or ot	ner piac	e)					
Balt	permit Depart Import any in		21. Signature of Fun Ro	eral Service Li nalid	wade, di	vector	. 2			_			W.	Baltimor	e Street
			23a. Part 1. Enter the shock or heart	disease, or co	emplications that cau	sed the death	n. Do not en	Balti ter the mode	more e of dyin	g, such as	212 s cardiac or	() 1 respiratory	arrest,		Approximate Interval Between
T.	Physician	i	Immediate Cause (F disease or condition	inal		mona		4050							Onset and Death
30	/Medical Examiner		resulting in death)	- 1		as a consequ		3.0							7.9.
2		Je.	Sequentially list cond if any, leading to imm	ditions, rediate	b Due to (or	as a consequ	uence of):								
08	ocuted nd ransit	Examiner	Cause (Disease or in that initiated events	ying	С.										
71/9/08	sate be executed by sician and the burial-transit		resulting in death) La	ist	Due to (or	as a consequ	uence of):								
687	tificate ig phys as the	ledic			d										
O. Box	because of Autenting Prysician: The law requires that the death certificate be executed to hours affer death. Funeral Director: Affer this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 U 9 Unknown	onths?		th 2 ☐ Fetal nt at time of d	death 3	☐ Ectopic pr ☐ Other (spe		/			3	23d. Date of de Month	livery Day Year
9.	rnar tn ed by detach		Part II. Other signific	ant condition	s contributing to deat	h but not resu	ılting in the u	nderlying ca	use give	en in Part	I.	23e. Did	tobacco	o use contribute to	o the cause of death?
んを足もカル	w requires that is been signed I should be det	ed by										1 🗆] Yes	2 □ No 3 □	robably 4 🗆 Unknown
<i>仏とととかわ</i> tal Record	has be	Completed	-									24a. Wa	opsy	prior to	utopsy findings available completion of cause of
48.	ficate r, page											perl 1 ☐ Yes	formed?	death?	Sea.
	/sicial s certi lirecto	Be C	25. Was case referre examiner? 1 ☐ Yes 2 ☐ ₩		Hospital:	atient 2 🗆	EB/Outpotio	nt 2 🗆 DO	Othe		e of Death			2 Files (2	" Hispire
Jo Ha	ig riny ter this neral d	ان. ان	27. Manner of Death		28a. Date of (Month,		28b. Time o		Bc. Injury Work	4 LI N				6 Other (Spe	ecity) buspice
	eath. or: Af the fur	catio	1 Natural 2 ☐ Accident	5 Pending investigat	ion	Day, Ieai)	injury	М		r Yes 2□]No				
Division of V	after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of	Injury - At ho , etc. <i>(Specif</i>)	me, farm, st	eet, factory,	office		28	Bf. Location City or To	(Street own, Sta	and Number or R ate)	ural Route Number,
900	to une note page of when the properties in the law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical Co	29a. Certifier 1 (Check only 2 one)	Certifying Medical Ex	Physician: To the beaminer: On the bas	is of examina	wledge, dea tion and/or in	th occurred anvestigation,	at the tin in my o	ne, date a pinion, de	ind place, ai ath occurred	nd due to th	e cause e, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
4	within To th	Me	29b. Signatule and tit	le of certifier	2 in	γ		A		number	9			Date signed (Mont	
		-	30. Name and addres	ss of person wh		of death (Item	23a) (Type,	Print)	<u>`</u>	, ,	-				
	Stat	e.	Jason Bl. 31. Date filed (Month)			istrar's Signal	ture	les S	(107	, 104	1504	M	0 2120	04
	Registra			JL30 8		see t	K de	antis							
DHM	H 17 Rev 1/20	001					ORIO	SINAL							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BOOKER ATHERINE 25,2008 JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE HOSPICE TIMONIUM MARIS STELLA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 217-40-8155 VIRGINIA **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantine in ust be notified at 1 ☐ Yes 2 No ESSEX J3ALTIMORE Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 21221 15.5.K LANDMARK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔣 No Specify. Specify: BLACK <u>გ</u> 3 M Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING COMPANY is marked other than SEAMSTRESS IRTH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVIS CAROL WILFORI ပ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. 64 LANDMARK COURT, ESSEX, MD WOODLON (FIANCE) DONNELL Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CODCEMETERY 07-31-2008 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
505EPH H. BROWN JR. FUNCERIL HOME
2140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee releams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician END STAGE RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation e Hospital or Attending 124 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and my investigation, in my opinion, death occurred at the time, date and place, and due to the control of the cont Medical 29a. Certifier investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 ERNESTINE WRIGHT

State Registrar

BOOKER

CATHERINE

			for State Registrar	State of M	aryland /		ment of I			ental Hy	gien Reg. N		2	4451
	Diversi		1. Decedent's Name (First, Middle, La	ist)	-					2. Date of De	ath		3.	Time of Death
	Physic /Medi Exami	cal	KATHERIN 4a. Facility Name (If not institution, gin		LLMI		b. City, Town,	or Locatio	on of Death	JULY	-	3 200 c. County of Dear		-43P M
	LAGIIII	iei	Genesis Elder		i-Med		Towso		n or Douth		1	Baltimo		
	Funeral Director		5. Social Security Number 214-26-1162		e (In yrs. last i 79	birthday)	f Under 1 Year Ionths Days	If Und	der 24 Hrs. s Min.	8. Date of Bir (Month, Da 05/07	1			(State or Foreign
	and bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Local	ion						10d. I	nside City Limits
	r 28a-f show	to	MD Baltimo	re	Tows	on								☐Yes 2 No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 7700 York Rd.				10f. Zip Code 2120	4			-	itizen of What C	Country?	
960	72 hours after death with the Maryland natural', or items 23a or 28a-1 show isoal Examinar must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Opinorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	S Decedent of I es, specify Cub Yes 2 No			cify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
5-0	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	a. Deceden	t's Usual Occup d of work done NOT use retire	pation during m	ost of workin	g	16b. I	Kind of Busines	s/Industr	y
12	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	5+) H	omem.		d)		-	Ow	n Home	,	
9	Hygi ther ther	Be Co	17. Father's Name (First, Middle, Last)		Omem	INCL	18. Mo	ther's Name	(First, Middle				
ılan	should be nd Mental marked o matic eve	To B	Henry W. Feig	9								Moore		
, Maryland 21215-0036	is 1 and 2 should life the stranger of the str		19a. Informant's Name/Relationship (Karen Billmire	**								or Town, State,		27514
Baltimore,	it of He		20a. Method of Disposition 1 Derial 2 Cremation 3	Removal from State	20b. Place ceme	of Dispositi	on (Name of ory or other pla	се)	July	ote 25		ocation - City o		
ţ.	Pa pa t		* 4 □ Donation 5 □ Other (Special	y)	Chesa	apeak	e Cre	n.	2008		Be:	ltsvil	le,	MD
Baj	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice	1588 - MO	1443	22. N	ame and Addre	ss of Fac	cility CAE	A/Ste	phe	en D.	Lohi	mann P
	10100		23a Part I Entry the disease or com	plications that caused	the death D	0/	I/ Gre	een	Pasti	ires L	r.	Towson	n, MI	21286 proximate
100	ni .		23a. Part1. Ent the disease, or comshock, or heart failure. List only Immediate Cause (Final	^				ng, such a	as cardiac or	respiratory a	rrest,		Inte	rval Between set and Death
	Physician / /Medical		disease or condition resulting in death)	a. POLIO	MYE (5							years
	Examiner						PD.	MU	SCL	EW	ER	AKNE	50	year
7	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. GENO	a consequenc	e of):								
V	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dysp.									4	ears
8760,	be exe	Ě	resulting in death) cast	Due to (or as	a consequence	e of):								
387	physic the l	dicai	•	d						-				
O. Box 6	that the death certificed by the attending posterior of detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		opic pregnanc her (specify) _	y				23d. Date of de Month	olivery Day	Year
P.0	The law requires that the ate has been signed by th bage 2 should be detache	Y Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the unde	rlying cause giv	ren in Par	rt I.	23e. Did t	obacco	use contribute	to the ca	use of death?
of Vital Records,	w requires that been signed b should be deta	q p					, , ,							4 Donknown
CO	faw rec as bee 2 shou	Completed								24a. Was	an	24b. Were a	utopsy f	indings available
Re	The la	mo								autor perfo	osy irmed?	prior to death?	complet	tion of cause of
ita	yaiclan: The la is certificate has director, page 2		25. Was case referred to medical examiner?					26. Pla	ice of Death	1 □ Yes (Check only o	2010 one)	0 1216	s 2 🗆	NO
Ž V	S S	20	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/C	utpatient	DOA OU					6 ☐ Other (Sp.	ecify)	
Division o	ding After funer	Certification:	27. Manner of Death Natural 5 Pending investigation Pending		Year) 28b.	Time of Injury	28c. Injur War	v at	28	8d. Describe I				
Divi	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		3 Suicide 6 Could not be determined	building, etc	. (Specify)					City or To	vn, Stat	,		
	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	Medicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination a	ge, death oc nd/or invest	curred at the tir igation, in my c	me, date : pinion, d	and place, ar eath occurred	nd due to the d at the time,	cause(s date an	s) and manner and place, and du	s stated. e to the	cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier				29c. Licens			1		ate signed (Mon	-	-
	2/		Ship	to MI)		DO	05	315	0 1	0 2	4 2 Y	20	21042 BO
	7		30. Name and address of person who		eath (Item 23a)	(Type, Prin	t)	00		0 5	UI	TEIK		MP
	Sta	e l	5 h Allun M Ac 31. Date filed (Month, Day, Year)	20 30-1-1-1	de Cienestone			/ / · · · ·		1) C	00	UMB	IA	51042
	Registra	· -	JUL 3 0 20	108	lo	A. C. C. C. C. C. C. C. C. C. C. C. C. C.								
DHN	MH 17 Rev 1/20	01		POLICIAN.	J. D.	GORA								
						GINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#1, perPHYS, #17-19a, perFH, G882, 8713/08, WS
State of Maryland / Department of Health and Mental Hygiene

Physician	1 - State Registrar 1. Decedent's Name (First, Middle, Last) Gerard Henry	Certificate of De	2. Date of De	
/Medical Examiner	Gerard Henry Bortstel 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Loc		22, 2008 11:15 PM 4c. County of Death Montgomery
Funeral Director	5. Social Security Number 102-14-3844 Usual Residence of Decedent	ast birthday) If Under 1 Year If	Under 24 Hrs. 8. Date of Bi lours Min. (Month, D	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23a or 28a-f show ent, the Weden Evanifier must be notified at e Completed by Funeral Director	10a. State 10b. County 10c. City	, Town or Location lver Spring 10f. Zip Code		10d. Inside City Limits 1 □ Yes 2 ♠No
th with 23a or ust be ral Dii		20910-		10g. Citizen of What Country? United States
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Midfall Evaniful must be notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.) pecify:	14. Race - American Indian, Black, White, etc. Specify: Caucasian
Maryland 21215-0036 Id 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, Inc. M. drent Evani. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired) Journalist	n g most of working	16b. Kind of Business/Industry Newspaper Union
yland ould be filed Mental Hy, arked othe attic event,	17. Father's Name (First, Middle, Last) Borstel Frederick Bortstel	18.	Mother's Name (First, Middle Me Marguerite —He	hrtens
	19a. Informant's Name/Relationship (Type Frint) Christopher L. Bertstel/Son	153 Garfield P	lace Maplewoo	·
Baltimore, permit. Pages 1 an Department of Hea Important: If item; any injury or other	4 □ Donation 5 □ Other (Specify) Ch	ace of Disposition (Name of metery, crematory or other place) esapeake Cremato 22. Name and Address of	•	20c. Location - City or Town, State Beltsville, Maryland
any perm	21. Signature of Funeral Service Idenses M00382	Kapp Funeral	. & Cremation Se	ervices ng, Maryland 20910-
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			
Examiner	Due to (or as a conseque	ence of):		σ
ificate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
K DS / DU, ertificate be ex ling physician as the burial Medical Ex	d			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Medical Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 0 4 □ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
hecologs, relatives that has been signed by 2 should be det	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
ding Physician: The law requiring Physician: The law requiring the ribing confiltrate has been such the ribing the ribing that			24a. Was auto perfo 1	
hysiciar this certiful director	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	- Other:	Place of Death (Check only of	
tal or Attending P rs after death. al Director: After t led in by the funera. Certification:	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of lnjury at Work? M 1 □ Yes	28d. Describe	how injury occurred
ital or Airal Directia	4 Homicide determined 28e. Place of injury - At nom building, etc. (Specify)		City or To	
the Hospi nin 24 hou the Funer npletely fil	29a. Certifier (Check only one) Certifying Physician: To the best of my know Medical Examiner: On the basis of examination and manner stated.	ledge, death occurred at the time, don and/or investigation, in my opinio	ate and place, and due to the n, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To t vith vith Con T	29b. Signature and title of certifier ALSTAD	29c. License nun		29d. Date signed (Month, Day, Year) 7 - 23 - 08
) 5 State	30. Name and address of person who completed cause of death (Item 2 JAWAR ARSHAD MD 931. Date filed (Month, Day, Year) 32. Registrar's Signatu	23a) (Type, Print) 201 MEDICAL CEA		ROCKVILLE MD 20850
Registrar .	JUL 3 G 2008	M. Pulliaged		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Julv1:00 p M 25 2008 ZDWAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. Lity, Town, or Location of Death 4c. County of Death Examiner 939 Anne Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan 20, 1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Min. 1 MM 2□ F Months Hours 218-36-8414 Vírginia 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it "Myrical Exprimes may be notified at any injury or other traumatic event, it "Myrical Exprimes" may be 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Maryland Glen. Burnie 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 939 Anne Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>ک</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HVAC Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) James Burnlev Minnie Lawhorne ည 19a. Informant's Name/Relationship (Type. Print)
Janice M. Burnley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 939 Anne Road, Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. Park Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 07-29-08 Glen Burnie, Maryland 21. Signature of Fundal Service License urly Polyniak Funeral Home P.A. 4 Mountain Road, Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. ock, or heart failure. List only one cause on each line. Do not enter the mode of July g, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Impordiate Cause (Final dilease or condition resulting in death) **Physician** /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine E Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death.

9 Funeral Director: After this certificate has been signed. burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? sig ificant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a Was an autopsy performed? Yes 2 ANo 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and manner stat within 2 To the I 29b. Signature and liftle of 29c. License number Name and address of person who completed ca ee of death (Item 23a) (Type 40HAR 31. Date filed (Month, Day, Year) State 2008 JUL 3 0 Registrar

Records, P.O. Box 68760, BERTHA Division or Vital

Hospital or Attending Physician:

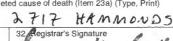
within 24 hours after death To the Funeral Director: the

Certification: To

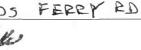
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of cedifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASAN

AWAN 31. Date filed (Month, Day, Year) JUL 3 0



M,D



29c. License number

00065861

29d. Date signed (Month, Day, Year)

25 2008

BALTIMORE, MD 21227

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4-40 AM 27 2008 DEN JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SAMARITAN MOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □ M 2 😿 F narylan Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examination at Yes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Tes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) partment Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental F 64 hir ٩ item 27 is marke other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Are. Sisler Nycholas Boy irles 3altimore, Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 of o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 30-08 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature & Funera) Service Licenses P. march sacto md, 2,229 Approximate Interval Between Onset and Death 23a. Pal. Envir the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. SEPSIS 2 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner week PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed Years HOMAN IMMUNODEFICIENCY VIRUS burial-trar Due to (or as a consequence of): the for use as IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) P.0. detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown POLYSU BSTANCE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 2 No 2 **V** No 1 ☐ Yes Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To o this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 2 ☐ Accident 5 Pending 1 Tyes 2 🗆 No 24 hours after death. Funeral Director; A investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD RES-000 27 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, ZUBAIK SHAIKH, Day, Year) 31. Date filed (Mont

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 4b, a, 25, 26, 29d per dr. , 881 07/29/08dhb Reg. No. 2 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 Day I Z 08ar **Physician** 13:10 Charles D. Breighner /Medical 4a. Facility Nama (If not institution, give street and number)

336 City View Terrace

Hospice of Memorial 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberland, Maryland 8. Date of Birth (Month, Day, Year) 6/30/1949 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 X M 2 □ F Maryland 217-54-6678 **Director** 59 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Cumberland MD **Allegany** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **Allegany** 21502 336 City View Terrace, Cumb., MD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 □Yes 2 No Specify þ 3 ☐ Widowed 4 🕅 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. public service Elementary/Secondary (0-12) College (1-4or 5+) retired fireman 12 Health and Mental Hygivem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Gerald Oswald Breighner Virginia Gertrude Brannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 336 City View Cumberland, MD 21502 Eric Breighner/son Department of Health Important: If Item 27 any injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State anatomy board 07/14/08 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service License And Thony II Pleasant Casan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ARCINDAH Onset and Death COLORSCTAL Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☑ No 2 No 1 □ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, Division of Vital Records, P.O. Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Danas man 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date sigged (Month, Day 7,14/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 24457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Bessie Bennett July 25 2008 9:26p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview M.C. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 23, 1920 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Funeral Days Hours Months 215-28-6971 1 ☐ M 2 🛣 F 88 Director ۷a Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Md. Baltimore Director Dundalk 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1926 August Ave. "natural", or items 23a 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 Z¥No Specify. Specify: White φ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Baltimore County 9 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel G Wood Clara Ann Roberts ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Bob Bennett 1601 Rita Road, Dundalk Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. July 30, X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale Gardens of Faith 4 Donation 5 Dother (Specify) 2008 Connelly Funeral Home Of Dundalk P.A. 7110 Sollers Point Road. 21222 21. Signature of Funerall Service Licensee 7110 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Onset and Death only one cause on each line. Immediate Cause (Final RESPIRATORY **Physician** wing disease or condition resulting in death) FAILURE /Medical Due to (or as a consequence of) Examiner month Sequentially list conditions, if any localing to limit the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner aftending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Who 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one)

State Registrar

BENNETT

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

KAVITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA

4940

32. Registrar's Signature

29c. License number

EASTERN AVENUE

ZES -000

PALTIMENE,

29d. Date signed (Month, Day, Year)

2008

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 24458 Reg. No. Certificate of Death dent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician Month /2.'40A™ /Medical Name (If not institution South Facility Town, or Logation of Death Examine If Unde If Under 24 Hrs. Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 219-76-4060 1 M 2 □ F Months Days Director 1/en Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 □ No timore 10e. Street and Momber 10f. Zip Code 10g. Citizen of Wh 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 📈 o Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working the. DO NOT ise retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than College (1-4or 5+) enstruction r's Name (First, Middle (First, Middle, Mai ce State, Zip Coden AM 21229 19a Informant's Name/Relation permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other tratonce. ton Bear CLEY ce City of Town, State Spring Rd 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) ral Service Licenses Approximate Interval Between Onset and Death or complications that caused the leath. ist only one cause on each line. . Enter the dis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ÛUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 Hospital: 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deatl Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 🗀 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #1, per ID, 9881 / 30/08 TT
State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Teresa Mary Ann Coleman Physician Month Dav Vear JULY e M 23 LEISTAN /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SomerForn HOWARD OLUMBIA If Under 24 Hrs. 8. Date of Birth (Month, Day, 0 2 / 0 5 / Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 ☐ M 2 🗷 F 215-14-6525 86 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Examination and any injury or other traumatic event, the Maryland Examination rust be notified at angles. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Glenwood **Funeral Director** 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3132 Longfield Rd. 21738 U.S.A. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Completed by If Yes, Give Year or Dates Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph J. Coleman Teresa Margaret Grabenstein 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3132 Longfield Rd. Glenwood, MD 21738 19a. Informant's Name/Relationship (Type. Print) Ann Sperry/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 7/30/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stephen D. Lohrmann P.A./CAFA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Towson, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZITEIMER ISGASE disease or condition resulting in death) 2 yrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any harmonic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a conse gience of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate has autopsy 1 □Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No A-ssisted Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this LAWIY 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 🗖 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 42-680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SABASHGKH MO BALTIMORE NATIONAL PIKE AC. ELLIGHT CITY 9051 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 24460 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Year 1:41 AM 26 2008 4a. Facility Name of not institution, give street and number) 4c. County of Dea 4b. City. Town, or Location of Death Hospit lhnorc 9. Birthplace (State or Foreign Country) Sex 10 M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Yrs. Usual Residence of Decedent 10b. Count wn or Location 10d. Inside City Limits Himore 1XYes 2 □ No 10f Zip Code 10g. Citizen of Wh Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, ☐ Yes 2 No 1 Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Nivorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Nymber or 524 S. W.C.K AHOS 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. P. rtt. Inter the disease, or complications that caused the hoc or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Im rediate Cause (Final disease or condition resulting in death) Pulmonary set and Death 巨いららしく nour Due to (or as a consequence of). Sequentially list conditions, any leading commediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

signed by the attending physicien and

certificate has been

Director: After this

filled in by the

death.

within 24 hours efter To the Funerel Direct

the Hospitel or Attending Physician:

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(somme)

Box 68760

Physician

/Medical

Examiner

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Completed by Funeral Director

To Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Mudical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner use as the burial-transit Physician/Medical þ Completed Be Medical Certification; To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

2 Accident

4 - Homicide

3 Suicide

29a. Certifier (Check only one)

Natural

9 Unknown

1 🗌 Inpatient

23e.	Did tobac	co use con	tribute to the cau	se of death?
	1 🗌 Yes	2 🗆 No	3 Probably	4 Denknown

24a. Was an 22 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 215 No

ne 5 Residence 6 (700 (0
ne 5⊟ Residence 6.0	700 (0

Other: 4 Nursing Hon 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		280
		М	1 🗆 Yes	2 🗌 No	
			*		

3 DOA

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Sign	nature	and title	of certifi	eç		
		0	750	ny	4	4	gn

5 Pending

investigation

6 Could not be determined

DO057011

26. Place of Death

29d. Date signed (Month, Day, Year) 08 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manis 02 A

31. Date filed (Month, Day, Year) Registrar

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05683 2008 24461 State of Maryland / Department of Health and Mental Hygiene Lawrence Graydon Carter Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 24, 2008 Year 1545 hrs Mertical Examiner Lawrence G. Carter 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimpre** 509 Rappolla Street If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY)Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Aug. 29, 1946 MD 215-46-9317 Director 1X M 2 F 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1X Yes 2 No Baltimore Baltimore or 28a-f shov MD Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21224 509 Rappolla Street 238 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married White Yes Yes 2X No specify: Specify 4 X Divorced If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Itealth and Mental Hygiene. Examine 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than atic event, the Medical Union Crane Operator 21215-0036 12th 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Willie Juanita Anderson John D. Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 Gorsush Road Lutherville MD 21093 Madelene Covacevich/sister 2 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, Bayview Crematory Burial 2 X Cremation 3 Removal from State 7/30/08 Baltimore MD permit. Pages
Department of
Important: I

Physician Medical taminer

21. Signature of Fur

a

Immediate Cause (Final disease

or condition resulting in death)

Sequentially list conditions.

if any, leading to immediate

23a. Par I. Enter the disease, or comb

and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician should be detached for use as the burial P.O. Box 68760 Records, has page certificate Division of Vital this After

Exar Physician/Medical ģ Completed Be

Certification:

Medical

2

3

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 23a,PII,2/,perME, g882 8/6/08 TT X UNPENDED AMENDED 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcohol abuse

Hypertensive

Due to (or as a consequence of):

Due to (or as a consequence of):

26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 DOA Inpatient 2 ER/Outpatient 3 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Pending Investigation

> determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated

> > Assistant Medical Examiner 32 Registrar's Signature

29b. Signature and title of certifier 1assel 30. Name and address of person who completed cause of death (Item 23a)

Could not be

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number July 25, 2008 O.C.M.E.

or Town, State)

24a. Was an

autopsy

✔ Yes 2

Nursing Home 5

performed?

28d. Describe how injury occurred

22. Name and Address of Facility 300 Mace Ave. Balto.

Approximate Interval

Between Dnset and Death

Year

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

death? 1 🗸 Yes

Residence 6 🗸 Other: Scene

28f. Location (Street and Number or Rural Route Number, City

Day

24b. Were autopsy findings available

prior to completion of cause of

Month

Connelly Funeral Home of Essex

atherosclerotic cardiovascular disease

3 Ectopic pregnancy

Healtyns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Fetal death

Other (Specify)

2

111 Penn Street, Baltimore, MD 21201

Other₄

Yes 2 No

2008 State Registrar

Melissa Brassell, MD

1 V Yes

27. Manner of Death

Accident

Suicide

Homicide

1X Natural

2

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 5:45 AM 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Lyndhurs] tumor 20 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days 1 M 2 □ F 213-36-5603 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla bepartment of Health and Mental Hygiene. Internet is marked to the "natural", or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he have also any injury or other traumatic event, he have any injury or other traumatic event, he have any injury or other traumatic event. 28a-f shov Baltimore 1 Yes 2 □ No Funeral Director md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lyndhurs 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 Deces 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 21215-0036 1 □Yes 2 No à Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Jones Elementary/Şecondary (0-12) College (1-4or 5+) EANER 216 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cant Are Balto sarah Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-3108 Arbutus mem. PK 22. Name and Address of Facility 21. Signature Funeral Service Licens Pass 270 Fred HILTON 23a. Purl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Bauto, nd, 2, 2229 Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The 1 ☐ Yes 2 No 1 □Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral 24463 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** p^{M} 22, 1300 Cho Don Ku July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min XXM 2 F 80 215-25-6362 Director 05-03-1928 Korea Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X☐ No MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 Lexington Road, Apt. 204 21207 Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 2 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Dong Cho Aie Gi Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 4980 Ellis Lane, Nam H. Cho - son Ellicott City, Maryland 21043 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) $\operatorname{Jul}^{\scriptscriptstyle\mathsf{Date}}$ Pages ' to Department of Important: If its any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25, 2008 Marriottsville, MD Crestlawn Cemetery 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licensee M000053 MMP, Inc., 7250 wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNRUMON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PSIS Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical attending p SE IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform certificate 2 **1**No 1 ☐Yes 2 ☑No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No Director: ,d in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) A Property of the Property of the Puncture of 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D52261 07-22-08 du QR B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Cr, Silver Spring, Alan R. Segal, MD, MD 20906 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien UU8

For State Registrar 1-Certificate of Death 3. Time of Death 2. Date of Death dent's Name (First, Middle, Last) **Physician** 0200M hAm AMSON /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 70 VOY tok KOAD 0/84 Survie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 12-10-1979 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F 214-94-8175 28 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7707 Norfolk Road 21060 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Yes 2X No f Yes, Give Year or Dates: 1½ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ning most of working Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If itam 27 is marked other the any injury or other traumatic event, The 1 once. None Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert S. Chambers, Sr. Ruth Eva M. Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E.M. Chambers - mother 7707 Norfolk Road, Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July ' 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 29, 2008 Meadowridge Mem. Pk. 21. Signature of Funeral Service Licensee MOQ 053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc. 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ul monary /Medical Due to (or as a consequence of): Examiner SCULAr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, by Physician/Medical signed by the attending phy: be detached for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9. Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate or Attanding Physicien: To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number mg address of person who complet - se of death (em 23a) (Type, Print) ONES MiAm ne 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 3 0

2008

ORIGINAL

DHMH 17 Rev 1/2001

Dolores M Ciesielski	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	24	4	6	E
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		I- For State Registrar	Certin	ficate of	7		Reg. No. 2000 244						100						
Physicia	_	Decedent's Nam			Date of De	of Death 3. Time of Death													
edical Examir	ner										2008	100	"	162	28 hrs				
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Death Baltimore											c. County						
Funeral		5. Social Security N	lumber	6. S ex		7. Age (I	n yrs. last	birthday)		r 1 Year	If Under		8. Date of	Birth(MN	I/DD/YYY	9. Birth		(State or	
Director		219-26-		1M	2 X F		70	Yrs		Days	Hours	'Min.	2-6-	193	8			VA	
, vi	-	10a. State	10b. County			10	c. City, To	own or Locat	ion							1	10d. In	nside City Li	imits
land f show a	ξ	MD Baltimore Dundalk											1 XYes 2 No				No		
the Maryland a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code 21222										10g. Citizen of What Country? USA							
with ns 23:		11. Marital Status 12. Was Decedent Ever in U.S.											cify Yes or						
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trahmatic event, the M-dix at Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 XWidowed 4 Divorced If Yes, Give Year						1	ican, etc.)	white, etc. Specify: White									
ours af	d by	or Dates:									on (Give ki			16b.	Kind of B	usiness/In	dustry	,	•
hin 72 h e. than "n die d E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)								mema		SC TOUTO	۵,		Own	Home	0		1
5-0036 led within 72 Hygiene. other than the Midical	E	17. Father's Name			по			Name (i	irst, Middl		•								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	Armon W			ton								nn E			,			
2121: 2121: ould be fil I Mental I marked ic event,	은	19a. Informant's Na	me/Relation	ship (Type	e, Print)			19b. Mailin	g Address	(Street	and Numb	er or Ru	ral Route N	lumber,	City or To	wn, State,	Zip Co	ode)	
e, MD 21215-003 1 and 2 should be filed withi Health and Mental Hygiene. item 27 is marked other th r transmatic eyent, the M-d		Michae		siel	ski-	- So								k,	MD 2	21222	2		
		20a. Method of Dis	position **Crematic	n 3	Removal	from State		ace of Disposematory or ot			etery,		Date	200	c. Location	ı - City or T	Γown,	State	
altimore, mit. Pages I ar partment of Her portant: If ite			Other S	-				view			_		9-08	Balt	imo	imore,MD			
Baltimore permit. Pages 1 Department of F Important: If injury or other		21. Signature of Fu	1101								of Facility	Bra	dley	-As	htor	ı Fui	ner	ral H	Iome
Physician	Н	23a. Part I. Enter the	ne disease.	r complica	ations that	caused the	e death. D	Do not enter t	he mode	134 of dying, s	Wil	rdiac or i	Spri	ng arrest, s	Road hock, or h	eart 2	1 2 2 App	2 2 proximate Int	iterval
/Medical		failure. List or	ily one caus	e on each	line.			scular Dis									Bet	ween Onse Death	et and
-xaminer		Immediate Cause or condition resulti			e to (or as				casc	_									$\neg \uparrow$
		Sequentially list co		b													₩.		
	ine	if any, leading to in cause. Enter Und	arlying Caus		e to (or as	a consequ	uence of):									. 20			
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):																	
ecut and		UNPENDED		d	MENDED												-		
760, cate be ext physician the burial	/Medical		,											23d. Date of delivery					
8760, tificate be ng physici as the buri	M/II	IF FEMALE: 23b. Was decedent			23c. If yes 1 Live	birth		ancy 2 F	etal death	3	Ectopic	pregnan	су	ľ	Month		Day	Yea	ar
Box 68760, e death certificate be enthe attending physician deforuse as the burial	sician	past 12 month		sknoun !	. —	gnant at tir	ne of deat	46-	ther (Spe					1					
he dea	Phy	Part II. Other sign				nown	ut not rec	culting in the	underlying	n cause o	iven in Pa	rt 1	23e D	id tobaco	co use con	tribute to	the ca	use of deat	th?
ires that the signed by the detach	þ	rait ii. Other sign	meant cond	itions (Jimbuang	to death L	ot not res	outing in the	andenym	y cause y	(VCI) III I I		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
rds, require been siy	Completed												24a. W	1 24a. Was an 1 24b. Were autopsy findings av					
COr law r has b	nple											P	autopsy prior to completion of ca performed? death?						
tal Rection: The		05.14/		_1 7						26 Dinas	of Death	Chaska		es 2 🗸	No	1 Ye	es .	2	No
Vital Rec ysician: The I his certificate I director, page	Be	25. Was case refe examiner?		<u> </u>	pital:	Innatient	2 J F	=R/Outnatien			Other		Home 5	Res	idence 6	Other			
of Vital Records, ing Physician: The law required After this certificate has been signeral director, page 2 should the state of the sta	. To	1 Yes 2 No Prospital: 1 Inpatient 2 FR/Outpatient 3 DOA Outel 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?											28d. Describe how injury occurred						
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Division tal or Attendir rs after death. at Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Trave, State)											er, City						
Could not be determined 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify))								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)																	
To wit	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)																	
		Jan	re /	yes	egun					O.C.M.E.				J	uly 26, 2	2008			
- 1		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201																	
		Tasha Gre	•		sistant				Penn :	Street,	Baltimo	re, MD	21201						
St Regist	ate trar	31. Date filed (Mor	UL 3 0	2008	The state of the s	Registrar's	signatur	Lipa	1										

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death July **Physician** 27, 2008 5:00 a M KENNETH D. DIXON JR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 906 Partridge Berry Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** November 26,1956 Months Days Min. 1 X M 2 □ F 51 Yrs 216-68-8343 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show id other than "natural", or items 23a or 28a-f shovevent, it will indical Examination required Maryland Anne Arundel Baltimore 1 ☐ Yes 2 🖪 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 U.S.A. 906 Partridge Berry Lane by Funeral filed within 72 hours after death ' Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever In U.S. Armed Forces? 11 Marital Status Black, White, etc. White 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Property Line Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Surveyor s 1 and 2 should be filed w f Health and Mental Hygier tem 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rudy Kenneth D. Dixon Thelma ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important: If Item 27 Is any Injury or other trau 906 Partridge Berry Lane, Baltimore, Maryland 21226 Mary H. Dixon (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Baltimore, Maryland 07-28-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 la. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Une Year Immediate Cause (Final **Physician** una Cancinoma disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial P.O. Box 68760, Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours are To the Funeral D 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D17873 In Charles Suite 205 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Newshall H. Levine 6569 North Nanshall H.L 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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AND THE STATE OF THE SECOND STATE OF MARY STATE OF MARY STATE OF MARY STATE OF MARY STATE OF MARY STATE OF THE SECOND STATE OF TH 24468 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** Charles Raymond Dayton July 26, 2:37 A M /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day You June 23, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Year 1942 Pennsylvania Months Days Hours 1 X M 2 □ F Min 220-40-0868 66 Director Usual Residence of Decedent 10b. County Arne Arundel 10a. State 10c. City, Town or Location Otenton ir than "natural", or items 23a or 28a-f show the Medical Evand we must be notified at 10d. Inside City Limits Director 1 ☐Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zin 1913 10g. Citizen of What Country? 689 Winding Stream Way, #101 20910 United States filed within 72 hours after death v I Hygiene. other than "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advertising Newspaper 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Pages 1 and 2 should I nent of Health and Mer Norris L. Dayton Alberta unknown unknown permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Patricia Dayton, Wife 689 Winding Stream Way, #101, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Portland Cremation 07/28/2008 Portland, Oregon 21. Signature of Fundal Service Ucensee M01113 22. Name and Address of Facility Harman Funeral Service, PA Sellet? 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Renal Disease Months /Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Congestive Heart Failure Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Bilateral Pneumonia Week Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ S/P colectomy for ischemic bowel 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 ☐ Yes 2 DXNo 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D0065485 07/26/2008 Ceparuch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Egistrar's Signature

State Registrar

JUL 3 0 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24469

	1- For State Certificate	e of Death	Reg. No.						
Physician/	Decedent's Name (First, Middle,Last)	Monti	of Death h Day Year 0435 hrs						
ledical Examiner	Gregory Bryan Dewey 4a. Facility Name (if not institution, give street and number)	July :	26, 2008 0433 IIIS						
	Interstate 695 at Route 7	Rosedale	Baltimore County						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219-25-0002 7. Age (In yrs. last birthda 22 7. Age (In yrs. last	Martha David House Men	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 1.1 y 22,1986 Country) Md.						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	a. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e 2 No specify: Sedent's Usual Occupation (Give kind of work doning most of working life. DO NOT use retired) Prentice 18. Mother's Name (First, Mailing Address (Street and Number or Rural Ro 017 Salisbury Ave.	10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? USA Is or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Steam Fitter LOCal 486 Middle, Maiden Surname) hester Gauslin						
Baltimore, permit. Pages I ar Department of He Important: If injury or other tr	4 Vigure of Commenter of Domental from State Crematory	Date or other place) s of Faith 22. Name and Address of Facility Connelly Funeral Ho 7110 Sollers Point	Rosedale						
Physician /Medical xaminer	23a. Part)l. Enter the disease, or complications that caused the death. Do not extended the List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	atory arrest, shock, or heart Approximate Interval Between Onset and Death							
frate be executed frate be executed g physician and s the burial - transit	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year						
ords, P.O. w requires that the seen signed by should be detact	Part II. Other significant conditions contributing to death but not resulting in	1 24	Se. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 1a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No						
Vital Reco	25. Was case referred to medical	26.Place of Death (Check only one							
Vital ysiciam ysiciam this certi	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outs	atient 3 DOA Other Nursing Home	e 5 Residence 6 V Other: Scene						
ion of ' tending Ph eath. tor: After t the funeral	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury Jul (Month, Cay Year) 28b. Tir 0000 h	escribe how injury occurred r of auto rolled over and ejected							
Division o spital or Attending hours after death. meral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Interstate/Expres	cation (Street and Number or Rural Route Number, City Town, State) ate 695 at Route 7, Rosedale, MD							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the Medical Certificati	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.	estigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. me, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
	29b. Signature and title of certifier Wyonte The Yell	29c. License number O.C.M.E.	July 26, 2008						
10		11 Penn Street, Baltimore, MD 21201	1						
State Registrar	A DE CARLETT I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24470 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2:50 рм Daisy L. Evans 07-23-2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lanham P.G. Magnolia Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Min 1□ M 2 🗗 F 65 Months Days Hours 578-60-2464 S.C. 06-28-1943 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Lanham 1 □Yes 2 □ No P.G. Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 2916 Brightseat Rd. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ♣ No 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 If Yes, Give 1X Never Married 2 ☐ Married 1 □Yes 2 No Specify SpecifyBlack 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Young Joe Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2916 Brightseat Rd. #102 Lanham, Md 20706 Loretta Caldwell/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-01-2008 Washington, D.C. Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral 108 W. North Ave Baltimore, Md 21201 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diata Causa (Final

Physician /Medical Examiner

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

Physician

/Medical

Examine

Funeral

Director

show

Director

Funeral

₽

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. Predical Examinat must be notified at

Baltimore, Maryland 21215-0036

the Maryland

law requires that the death certificate be executed attending physician and for use as the burial-tran ed by the a signed I peen has page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death) Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b									
that initiated events resulting in death) Last	c									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of d Month	elivery Day Year							
Part II. Other significant conditions on	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 1	to the cause of death? Probably 4 ☐ Unknown							
		autopsy prior to	autopsy findings available completion of cause of ?							
25. Was case referred to medical examiner?		th (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Other (Sp	pecify)							
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,							
29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	vician: To the best of my knowledge, death occurred at the time, date and place inner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(s) and manner urred at the time, date and place, and d	as stated. ue to the cause(s)							

29d. Date signed (Month, Day, Year)

eensburg Rd Hyattroille MD

State Registrar cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day VIRGINIA HUGHES **ENSOR** 2008 8:35 P M JULY 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2 🗗 F Director <u>216-38-3549</u> 10/19/1938 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 HIGH ACRE DR., APT. 105 21157 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: ò Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING **BOOK WAREHOUSE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THURSTON EDWARD ENSOR, SR. HILDA HUGHES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 7 19a. Informant's Name/Relationship (Type. Print) LINDA WOOD - FRIEND 1253 EMERALD RIDGE DR., WESTMINSTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOSLEY CEMETERY 8/2/08 BUTLER, MD 21 Signature of Juneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a, Part 1. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 12/07/13 months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ${}_4\,\square\,$ Nursing Home ${}_5\,\square\,$ Residence ${}_6\,\Sigma$ Other (Specify)HOSPICE1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. May er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea... (Month, Day, Year) Natural 5 | Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20059943 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strey Svite 301

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** OS PM HAZEL 2008 7 3 /Medical SULY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKING BAWIEW INONE MEDICIAL CENTER Birthplace (State or Foreign Country) If Under 1 Year 6. Sex Hrs. 8. Date of Birth (Month, Day, Year) Funeral Social Security Number 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 🖳 F Director 215-30-9185 73 Maryland Aug. 23, 1934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Columbia 10f. Zip Code Maryland Howard 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or uny or other traumatic event, the Medical Examination and the samination. 5824 Wyndham Circle #202 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**XXX**No Specify. Black ğ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Chandler Jessie Hudnall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly S. Ervin - Daughter 8904 Orwood Lane, Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 4 ☐ Donațion 5 ☐ Other (Specify) Atlantic Crematory 7/25/2008 Glen Burnie, MD 21. Signatur of Funeral Servi Licen e 22. Name and Address of Facility 5555 Twin Knolls Road M01283 Witzke Funeral Home, Inc. Columbia, MD 21045 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEMORRHAGIC 2 DAYS STROKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit certificate be executed Due to (or as a consequence of): Box 68760, led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) P.0. 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No certificate 2 🗌 No 1 ☐ Yes 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES . 000 30. Name and oddress of person ho completed cause of down (Item 23a) (Type, Print) MARTINISIV MI 4940 ENSTERN ENERVE BALTIMORE IN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 0 Registrar

08-05510 Briar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24473

in Edward Fo		1- For State Critificate of	Death Re	eg. No.
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last) Brian Edward Fox	2. Date of Deat Month July 18, 20	th 3. Time of Death Day Year 0915 bro
Exami		4a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of Death Rosedale	4c. County of Death Baltimore County
		7402 Meadow Branch Court Apt. B 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		215-86-6908	Months Days Hours Min. 02/16	/1966 Foreign Country) MD
any	- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Limits
≱	٦	MD Baltimore Rosedale		1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	7402 Meadowbranch Ct Apt. B	21237	U.S.A.
h with the mas 23a be not	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces?	s Decedent of Hispanic Origin? (Specify Yes or No es, specify Cuban, Mexican, Puerto Rican, etc.)	Willie, etc.
ter deat ", or ite	Fun	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 No specify:	Specify: White
tours af natural	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden during m	nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired)	16b. Kind of Business/Industry
36 hin 72 h e. than "r sdical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Laborer	Construction
15-0036 filed within 7 if Hygiene. ed other than	e Con	17. Father's Name (First, Middle, Last) Hansford Eugene Fox, Sr	18.Mother's Name (First, Middle, Elizabeth Ar	nn Smith
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To B	19a. Informant's Name/Relationship (Type, Print) Hansford Eugene Fox, Jr/ I Me	g Address (Street and Number or Rural Route No Prsey Ct. Apt. K Mic	inber, City or Town, State, Zip Code) 11220 MD 21220
e, MD 1 and 2 sho Health and item 27 is		1 20h Place of Dispos	sition (Name of cemetery, Date ther place)	20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		
Balti permit. Departi Import		14 1 0 3	117 Creen Pastures 1	ephen D. Lohrmann P.A Dr. Towson, MD 21286
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or respiratory a	Approximate Interval Between Onset and Death
Jedica Examine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	one) intoxication	
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,	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
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OX 68760, eath certificate be exuenting physician for use as the burial.	n/Me		Fetal death 3 Ectopic pregnancy	Month Day Year
Box 6: death cert the attending	sician/	past 12 months? 4 Pregnant at time of death 5 0 1 Yes 2 No 9 Unknown	Other (Specify)	
O. B. at the de	E	Part II. Other significant conditions contributing to death but not resulting in the	e underlying badde given in a service	id tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
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Records, The law requir ficate has been s	≀I 5			utopsy prior to completion of cause of death? es 2 No 1 Yes 2 No
Vital Rec			26.Place of Death (Check only one)	
of Vital ng Physician After this cert	TO B	1 Yes 2 No	Leat Day	Residence 6 Other: Scene
on of nding I th.	7 .	27 Manner of Death	· 11 am 1 Yes 2 X No unk	
Division tal or Attendil rs after death.	Cortification.	2 Accident Investigation 3 Suicide 6 X Could not be house	treet, factory, office building, etc. 28f. Locati	on (Street and Number or Rural Route Number, City wn, State) 7402 Meadow Branch Apt B Rosedale, MD
ospital bours a	>	293 Certifer	coursed at the time, date and place, and due to the	cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis.	completely lined in by	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of the basis of the basis of the basis of examination and/or investigation and the control of the basis of the basis of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the basis of	igation, in my opinion, death occurred at the unie,	date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	1 2	29b. Signature and title of certifier	29c. License number O.C.M.E.	July 19, 2008
, or d		30. Name an address of person who completed cause of death (Item 23a)		
1 Bry		Margarita Korell MD. Assistant Medical Examiner 111	1 Penn Street, Baltimore, MD 21201	
	Ctal	31. Date filed (Month Pay, Year) 2000 32. Registrar's Signature	6 - 69 0	

Registrar

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			State of Maryland / Departm		and Mental Hy	'	HHR	2447	L
			1. Decedent's Name (First, Middle, Last)	cate of Death	2. Date of D	Reg. No.	000	3. Time of Death	
	Physicia	an			Month	Day	2008	8:45A	
	/Medic Examin		James M. Forbes 4a. Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location o	of Death	4c. Co	ounty of Death	3.40.	$\overline{}$
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	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Lim	nits
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Ë	Page Jent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview C	1	7-23-08	Bal	timore	, MD	
Baltimore	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.	1		ne and Address of Facilit		-Asht	on Fur	eral Ho	ome
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as	s cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death	h h
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5	tal or s afte al Dir ed in	Cert	a limiting sic. (specify)		City of	i Owii, Olale)			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director in th	edical	29a. Certifier (Check only (Ch						
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1	rT		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10000	10	1	11110	U	
٢			Dr. Tamer Smith 9000 Franklin	Savare	Dr. Bal	timo	e mel	2123	7
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· ·	Examir		4a. Facility Name (If not institution, give	street and number	7)		4b. City, Town, or		of Death	_	4c. County	of Death		
	Funeral Director		1740 E. 25TH ST. 5. Social Security Number 6. Se 214-64-7983	x 7. A	ge (In yrs. I	ast birthday) Yrs.	BALTIMO If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day			place (State or Foreign ntry) MD	
	land bw		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation					1	I0d. Inside City Limits	_
	the Maryland r 28a-f show	Director	MD		BAL	rimore							1 XYes 2 □ No	
	3a or 2	al Dire	10e. Street and Number 1740 E. 25TH ST.				10f. Zip Code 21213			1	10g. Citizen of \ USA	What Cou	ntry?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine unt be notified and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 □ Yes 2X If Yes, Give Year or Dates	?] No	1	Vas Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican Specify:	gin? (Specii , Puerto Ric	y Yes or No- an, etc.)	14. Rad Blad	ce - Ameri ck, White, y: BL		
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and 2	be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last)		I	CRO	JING GOAL		r's Name (F	First, Middle,	Maiden Surnan		1100110	_
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Balt	permit. Departi Imports any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FN 2007-09 EASTERN AVE., BALTIMORE, MD										Ж. НМ. 21231	
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38760,	ilcate be executed physician and s the burial-transit	dical E		d	s a consequ	erice oi).								_
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Fetal	death 3	Ectopic pregnanc Other (specify)	у				ite of delive	rery Day Year	
ords, P.	equires that en signed b ould be deta	ρ	Part II. Other significant conditions co	ntributing to death	but not resu	Iting in the ur	derlying cause give	en in Part I.					he cause of death? bably 4 Unknown	
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f Vit	ysiclar iis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1	ient 2 ☐ I	ER/Outpatien	t 3 DOA Othe			Check only or 5 ☐ Resid		ner (Spec	whospile	-
o uo	ding Pt h. After th funeral	tion: 1	27. Manner of Dealh 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury ay, Year)	28b. Time of Injury	28c. Injur Work	y at	280		ow injury occur			_
Division	al or Atten s after deat Il Director: sd in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	ijury - At hoi tc. (Specify	me, farm, stre	eet, factory, office	ies Z		Location (S City or Tow	treet and Numl n, State)	ber or Rur	al Route Number,	
	e Hospit 124 hours e Funers letely fille	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the bes ner: On the basis and manner s	of examinat	wledge, death ion and/or in	occurred at the tire estigation, in my o	me, date an ppinion, dea	nd place, an th occurred	d due to the o	cause(s) and m	anner as	stated. to the cause(s)	Ī
	To th Withir To th comp	Me	29b. Signature and title of certifier				29c. Licens				29d. Date signe	ed (Month	Day, Year)	
	2		30. Name and address of person who co	empleted cause of	death (Item	23a) (Type. I	Print)	0680			7/	23/0	D .	
			ELYIE MILLIEU 31. Date filed (Month, Day, Year)	W F	Mar's Signat	un st	Reister	1 DWI	n, MO	21137	6			_
	Sta Registr		JUL 3 0 200	8 Separa	بالحر ب	Los	NE .							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08:54AM 26 Physician 200 a /Medical 4c. County of Death Facility Name / institution, give street and number, wn, or Location of Death Examiner BULME ALtimore WASHINSTON 8. Date of Birth (Month, Day, Year) Nov.25,1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Under 24 Hrs **Funeral** Hours Days 1 □ M 2 🗷 F Months 93 Maryland Director 215-16-7413 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Vedical Evanimer must be notified at Maryland Harford 1 ☐ Yes 2 No Havre de Grace Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 121 Heron Court 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify Specify: White ≥ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Librarian permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James J. Babka Elizabeth Ε. Neugibower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard J Gadd Jr. (Son) 121 Heron Court, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 07-30-08 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 130 East Fort Avenue, Baltimore, Maryland 21230 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final **Physician** emente 1 Par direase or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p as IF FEMALE: 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy r this certificate haral director, page perform of Vital 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□N 1 Inpatient 2 A/Outpatient 3 DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director: completely filled in by the fi 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 112009

State Registrar 10

of death (Item 23a) (Type, Print)

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Amend #30 per DVR g881 //30/08 TT
State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #5, perFH G882 8/4/08 TEertificate of Death

Reg. No. 200 Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year <u>10:1</u>5₽[™] **Physician** GREEN, SR. WILLIAM STUART 2008 JULY 28, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK CITIZENS CARE & REHABILITATION FREDERICK 5. Social Security Number 94 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1 🕅 M 2 🗆 F 5/29/1933 MARYLAND 75 215-26-8789 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantinar must be mailted at 1 ☐ Yes 2 No Director MT. AIRY MD CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21771 5938 RIDGE RD. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: WHITE δ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any hijury or other traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) PIANO TUNING MUSIC 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HILDA ADELAIDE TAYLOR STUART FRANCIS GREEN ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILLIAM S. GREEN, JR. 5938 RIDGE RD., MT. AIRY, MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PATAPSCO CEMETERY 8/1/08 PATAPSCO, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funcial Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Failure MONTHS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical onsequence of): Pehn Ilclein MENTHS. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed ng physician and as the burial-transit Due to (or as a consequence of) P.O. Box 68760. requires that the death certificate be Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? has been signed be 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe page 1 ☐ Yes 2 No 1 ☐Yes 2 No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural 2 Accident To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatule and 08 20062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Praveen Kumar Bolarum, MD Citizens Care & Rehab Frederick, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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OPIGINAL

ORIGINAL

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		1 - For Amend Item Registrar	State o 23a per	f Marylan dr, g88	d/Depa 1,0//2	rtment of	Health f Death	and Mer	ntal Hyg	iene _{eg. No} 20	08	24478
Physi		Decedent's Name (First, Middle, SYLVIA						2.	Date of Dea Month	th Day	Year	3. Time of Death
~ /Med Exam		4a. Facility Name (If not institution, LEVINDALE HEBRE		mber)		4b. City, Town		of Death	4c. County of Death			
Funera Directo	_	5. Social Security Number 218-05-6908	. Sex 1 □ M 2 X F	7. Age (<i>In yrs. I</i>	ast birthday) Yrs.	If Under 1 Ye Months Da		Min. 0	Date of Birth 19/28/1	912	9. Birthp Cour	lace (State or Foreign try)
laryland show	J.	Usual Residence of Decedent 10a. State 10b. County MD BALTIM	ORE	10c. City BA	, Town or Lo	cation E					1	0d. Inside City Limits 1 ☐Yes 211 No
with the M la or 28a-f t be notifie	Director	10e. Street and Number 6622 CHIPPEWA D	RIVE			10f. Zip Cod 2120			1	10g. Citizen of What Country? USA		
filed within 72 hours after death with the Maryland half lightly with an "half lygene" of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrier 3 ☑ Widowed 4 □ Divorced	Armed Fo	2X No		Was Decedent Was Decedent If Yes, specify C			y Yes or No- can, etc.)		ice - Americ ack, White, ify: WH	
within 72 hou iene. than "natura he Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (I-4or 5+)	(Give life. L	dent's Usual Oc kind of work do DO NOT use re CHER	ne durina mo	est of working		16b. Kind of F		ol SYSTEM
ed all be	To Be Co	17. Father's Name (First, Middle, La ELCHANON	ast)	FE	LDMAN		18. Moth		First, Middle,	Maiden Surna S	ARTIS	KY
t and 2 should Health and Mer tem 27 is marke		19a. Informant's Name/Relationship LAWRENCE GOLDST				ng Address (Str STONE C						
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Method of Disposition X Burial 2 Cremation 3 4 Donation 5 Other (Spe		State C	emetery, crer	sition (Name of natory or other ISRAFIL	piace) ¦	Date 07/20/		20c. Location	•	
permit. Departr imports any Inju	ouce:	21. Signature of Funeral Service Li	ensee		8	2. Name and Ad 900 REI	dress of Faci STERST	OWN RC	LEVINS	ON & P	ROS., E,MD,	21288
Physiciar /Medica Examine	i r	23a. Part / Inter the disease, of de shot k or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to him solutions cause. Enter Underlying Cause (Disease or injury)	a. A. Due to	caused the death seach line. (or as a consequentia	uence of):							Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dical Examiner	That initiated events resulting in death) Last Due to (or as a consequence of):										
eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live I	tcome pf pregna pirth 2 Feta nant at time of do own	Ideath 3□	Ectopic pregna					ate of delive	ery Day Year
quires that the de n signed by the a	þ	Part II. Other significant condition	7	eath but not resu	ulting in the u	nderlying cause	given in Part	t I.	23e. Did to		ntribute to t	he cause of death?
	Completed		,						24a. Was a autop perfor 1□ Yes	sv	o. Were auto prior to co death? 1 □ Yes	opsy findings available mpletion of cause of 2 No
Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No			ER/Outpatier	1 30 DOX	Other: 4 🗆 N		e 5 □ Resid	lence 6 □C		fy)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Oculd no determin	tion t be 28e. Place	th, Day Year) of injury - At hoing, etc. (Specifi	28b. Time of Injury	М	njury at Work? 1 ∐ Yes 2 [ice	□No				al Route Number,
Hospital of the Police of the	Medical Cer		Physician: To the xaminer: On the b	asis of examina	tion and/or in	vestigation, in	ny opinion, d	eath occurred	at the time,	date and plac		
To the within 2 To the comple	Med	29b. Signature and title of certifier.	and man	ner stated.		29c. Lic	ense number			29d. Date sign		
		30. Name and address of person w	ho completed cause	se of death (Item	23a) (Type,	Print)	211	1	A 15	July	18,0	ire M
S Regis	tate strar	31. Date filed (Month, Day, Year)	2008	se of death (Item	ture of	all ,	x pe	a est e	1500) Da	Non	/ ZIZIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 16b,1 per fh/phys 881,07/29/08dhb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Louise Garrett **Physician** Cravle++ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick Multi-Care saltimore 8. Date of Birth (Month, Day, Year) 12.31.1924 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 220-14-0138 1 □ M 2 🗀 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Baltimore 1 Tes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Fog (Give kind of work done during most of working life. DO NOT use retired) London Elementary/Secondary (0-12) College (1-4or 5+) 8th عصر 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ive. Baltimore Hatricia Page Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition v Forest 7/9/2008 Baltimore MD
22. Name and Address of Facility Vaugna C. Greene Funeral Services 16 Burial 2 ☐ Cremation 3 ☐Removal from State Garrison Forest 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 4905 York Ad Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hysician 2 heimeus Viedical Examiner new tensine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 menths? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ۵ 2 / No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an was a... autopsy performed? Ves 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and peanly stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064788 8 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address ROYAL AUE, BALT INORE ND

State Registrar

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31. Date filed (Month, Day, Year)

JUL 30

2008

MT.

1600

32. Pagistrar's Signature

W

Brenda Lee 08-05237 UNKUNK Hotfiell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 24480

		1- For State Registrar Certificate of Death	entai riygiei	Reg. No.									
Physic		Decedent's Name (First, Middle,Last)	2. Date Mor	e of Death	3. Time of Death								
ledical Exam	iinei	Brenda Lee Hatileid	July	/ 7, 2008 [*]	2217 hrs								
		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 4501 Old Frederick Avenue Baltimore	on of Death	4c. County of De	ath								
Funeral			Inder 24Hrs. 8. Da	ate of Birth(MM/DD/YYYY) 9.	Birthplace (State or								
Director		220-82-9475 1 M 2XF 45 Yrs. Months Days Ho	ours Min.	r 7, 1963	eign Countr M ary1and								
	1	Usual Residence of Decedent	1 121		Flat y Land								
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
Maryland 28a-f show any <u>d at once.</u>	ţį	MD Baltimore 10e. Street and Number Life Zin Code			1 Yes 2 No								
e Mar or 28s	Director	106. Street and Number 10f. Zip Code 21230	0	10g. Citizen of What C									
with the 18 23 a	la [11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C	_		nerican Indian, Black,								
death r item	Funeral												
after aff., o	by F	white											
hours 'natur Exam	ed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Ginduring most of working life. DO NO		ne 16b. Kind of Busines	ss/Industry								
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10 housekeeping											
5-00 ed with ygien, other	l o	10 0 housekeeping 17. Father's Name (First, Middle, Last) 18.Mott		private Middle, Maiden Surname)	homes								
215 be file ntal H rked o	Be (Ben George Rone		oba Medary									
21 should ond Me is ma	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	Number or Rural Ro	oute Number, City or Town, St	ate, Zip Code)								
, MI and 2 s salth a em 27		Catherine Linder/sister 1022 Shore Acres 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in Department of Health and Mental Hygiers in Innoversus: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City	or Town, State								
Itim it. Pa irtmen ortant		4 Donation 5 X Other Specify: in state	100										
Ba perm Deps Imp		21. Signature of Funeral Service Licensee Ronald S Wade Director State Anatomy	Board 65	5 W. Baltimore	Street								
Physician	1	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	21201 as cardiac or respira	atory arrest, shock, or heart	Approximate Interval								
/Madical xaminer		Immediate Cause (Final disease a. Blunt Force Injuries and Asphyxia											
		or condition resulting in death) Due to (or as a consequence of):											
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
_	Examine	Causs. Enter Underlying Cause (Disease or injury that initiated c											
cecuted n and - transit		events resulting in death) Last Due to (or as a consequence of): d.											
a a a	Medical	UNPENDED AMENDED											
68760, certificate be exiding physician	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	very								
Sox 687 leath certifu e attending for use as t		Program of death	opic pregnancy	Month	Day Year								
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Other (Specify)											
od by t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23	Be. Did tobacco use contribute	to the cause of death?								
S, P	ed by		1	1 Yes 2 No 3 F	robably 4 🗹 Unknown								
ords w requires been as been s	plet		24		autopsy findings available to completion of cause of								
of Vital Records, ng Physician: The law requir offer this certificate has been si neral director, page 2 should b	Completed		1	performed? death ✓ Yes 2 No 1 ✓									
Vital Recysician: The his certificate director, page	Be		ath (Check only one	e)									
of Vital Physician: er this certif	유	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at We			her: Scene								
	Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at World 28	— ISubie	escribe how injury occurred ect struck and asphyxia	ted								
	licat	2 Accident Investigation 28e Place of Injury. At home form street feature office heilding		ocation (Street and Number or	Rural Route Number City								
Divis spital or At cours after d neral Direct filled in by	erti	Suicide 6 Could not be determined (Specify) Woods	or	Town, State) Old Frederick Avenue, Bal									
To the Hosp within 24 ho To the Func completely f		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to	the cause(s) and manner as s	tated.								
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the tim	ne, date and place, and due to	the cause(s)								
	Σ	29b. Signature and title of certifier 29c. License number	OCME	29d. Date signed (i	Month, Day, Year)								
		Thoobe M. Kigg Try um O.C.M.E.		July 8, 2008									
	ı	 Name and address of person who completed ause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, E 	Baltimore MD	21201									
St	ate	31 Date filed (Month Day Voor) 23 Secretaria Carata as											
Regist	rar	JUL 3 2008 Szaggistrar s signature											

Physician /Medical Examiner The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760 ed by the a steen signed by should be deta has te 2 s

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Examiner

Physician/Medical

3

Completed

Be

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Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination.

To the Hospital or Attending Physician: funeral directo after death within 24 hours a

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death Natural 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title, of certifier 29c. License number 29d. Date signed (Month, Day, Year)

COURT ROAD RANDALLSTOWN

State Registrar 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CLIFFONDFABERME

31. Date filed (Month, Day, Year)

JUL 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** ELIZABETH MARIE HUMMEL 2008 3:00 P JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER 3035 HALTER RD. CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🔀 F 104-16-0709 85 3/09/1923 NEW YORK Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2√∑ No Director CARROLL MD WESTMINSTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3035 HALTER RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: WHITE ۵ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 HOUSEWIFE HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GORMAN ပ LOUIS EDGAR FROST CATHERINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3035 HALTER RD., WESTMINSTER, MD 21158 NANCY A. BARTON - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition SOUTH CARROLL CREMATORY 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State WINFIELD, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Funeral Service License

Physician /Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

ed by the

Box 68760,

P.O.

Division of Vital Records.

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show amy Injury or other traumatic event, It. Medical Examination to the traumatic event, It. Medical Examination and by notified at once.

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examine and

Physician/Medical

2

Be Completed

Medical Certification: To

filled in by the funeral

death. hours after death

within 24 hours a

To the Funeral I

	or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only no cause in each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Colon Cancer	Oriset and Death
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	b	
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of);	
	d	
IF FEMALE:	23c If yes outcome of pregnancy	4-17

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No 9 Unknown

da

1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death q | Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of deliver Month Day

23e. Did tobacco use contribute to the cause of death?

21157

Ye ar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed

26. Place of Death (Check only one) Other: 4 \(\Bigcap \) Nursing Home \(5 \) Residence \(6 \) Other \(\(\text{Specify} \)

25. Was case referred to medical examiner? 1 Tes 2. ☑ No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

254 E. MAIN ST., WESTMINSTER, MD

1-Natural 2 Accident 3 Suicide

4 Homicide

TARIQ

31. Date filed (Month, Day, Year)

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

westminister ND 21157

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tile of certifie

29c. License number

Roond

29d. Date signed (Month, Day, Year)

State Registrar MACHMOUD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24^{Day} July 2008^a 12:45A M **Physician** Elsbeth Frida Anna Hughes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Oct. 25, 1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months Days 1 □ M 2 🙀 F Germany 77 Director 577-78-8875 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be suffiled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Completed by Funeral Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 Germany 6075 Warmstone Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frida Gehrke Wilhelm Pohl ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6075 Warmstone Court Columbia, MD 21045 (Husband) James W. Hughes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atlantic Crematory 7-29-2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road Columbia, MD 21045 Approximate Interval Between Onset and Death 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Obsmuchy ummary 1cars **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day P.0. 9 Unknow been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Ves 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPLA 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) eral Director: After th filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

FARUN

31. Date filed (Month)

Charles

Jo Panson MO Z1204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. WMWis

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Doesdent's Name (First, Middle, Last 2. Date of Death **Physician** Jul /Medical 4b. City, Town, or Location of Death (If not institution, give street and number) Examiner ruso 1 57 pspice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours MARY Jano 1**X**M 2□ F Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hyglene. Into If Item 21 is an art-fed other than "natural" or items 23a or 28a-f show into If Item 27 is an art-fed other than "natural" or other traumatic event, the Modical Examinar must be notified at any or other traumatic event, the Modical 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Funeral Director timore 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO TWOT use stired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be Ames ocars ျ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Numbe permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once. Stones 20b. Place of Disposition (Name of Cometery, crematory or otherplace) 20a. Method of Dispo 1 Burial 2 Cremation 3 Removal from State ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Liverses BAHO Approximate Interval Between Onset and Death dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part J. Enf r the slock, hear file Immediate Cause final diselise condition resulting in death) neumoni **Physician** lange /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the darrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ n 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSP: CC Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1-Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

Jely 25, 200 f 29c. License number 29b. Signature and title of certifier 670/N-Charles St. Bult: Md Z. 201 30. Name and address leted cause of death (Item 23a) (Type, Print) 6-BMC 32. Agistrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 24485 1 - For State Registrat Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:15 AM M Charles Lindsay Jarvis Jr. July 23, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartland Health Care Adelphi Prince George's Adelphi If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1⊠M 2□F 55 Yrs. Director 215-58-7412 02/13/1953 VA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov the Medical Examiner must be notified at 15 Yes 2 No MD **Prince Georges** Hyattsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 20783-United States 1801 Metzerott Rd. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman pernit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: if item 27 is marked other ti
any njury or other traumatic event. The 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lindsay Jarvis Sr. Jean Elizabeth Coulson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret J. Bennett/Sister 3001 Veazey Ter. NW #716 Washington, DC 20008-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jul 26 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2008 21. Signature of Funeral Service License 22. Name and Address of Facility
Rapp Funeral & Cremation Services M00382 933 Gist Ave. Silver Spring, Maryland 20910-Munanu 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** 0 MINIS /Medical Due to (or as a consequence of): Examiner RIPHERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit BIABETES Due to (or as a consequence of) Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No DISEASE 24b. Were autopsy findings available prior to completion of cause of death? KENAL 24a. Was an CHRONIC autopsy performed? certificete 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 EN/Outpatient 3□ DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Mann of Death 1 ✓ Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerei Dire Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated

State

Tul 31. Date filed (Month, Day, Year)

30. Name - d address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

10810 DARNESTOWN RD #202, GAITHERSBURG MD 32. Régistrar's Signature

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

.O. Box 68760,

Division of Vital Records, P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 2:46 P M Cornelia Jones 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace State or Foreign Age (In vrs. last birthday) **Funeral** Days North Corales 30-Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at saltimore 1 Pres 2 □ No Ma Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? "natural", or items 23a or 051 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or itel 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
iffe. IOO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4 or 5+) me MAICER Department of Health and Mental Limportant: If them 27 is many injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BROOKC OR Lawson ပ္ 19a. Inform Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 Burial 2 F Cremation halto. Mid. 4 Donatio 5 P Other Specify te, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 2 shock, or heart failure Immediate Cause (Final disease or condition resulting in death) seizure Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed Alzheimer's disease burial-transit ears and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed t of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page perform 2 □ No 2 100 1 Yes or Attending Physician: 25. Was case referred to medica examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No n Inpatient 2 ER/Outpatient 3 DOA ည this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the 24 hours after deat Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Ecrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only

within 2 To the I the ٥

State Registrar

DHMH 17 Rev 1/2001

JaniceLeuna 31. Date filed (Month, Day, Year) JUL 3 0 2008

, Medical doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 7:55 A. M. 141 /Medical 25 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maris Baltimore Hospice OWSON If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 ☐ F Director 27, 1924 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Ballimore

10e. Street and Number 10g, Citizen of What Country? 10f Zip Code US 21222 death v Funeral OURTWAY 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Important: If item 27 is marked other any injury or other traumatic event, the Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be family nent of Health and Mental Joseph A. Kraje I 19a. Informant's Name/Relationship (Type-Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kraj Lane, Beair, Maryland 21014
20c. Location - City or Town, State David H Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition رحمح "لالدر 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart of Josus Com. 2008 21. Signature of Fundal Pervice Licensee Road Dundalk Maryland21222 art1. Enter the disease, or complications that shock, or heart failure. List only one cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest A roximate Interval Between Onset and Death 20/51/0 SC (510823 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as the I IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the detached 9 Unknown r significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? funeral director, page 2 certificate Vital 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ō this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Notural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Marical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature le of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 66 0

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Registrar

State

ORIGINAL

2300 DULANEY VALLEY ROAD

TIMONIUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

EDDIE NAKHUDA, M.D

31. Date filed (Month, Day, Year)

			For 1 _ State	State of M		l / Depa	rtment	of H			ntal Hy		71	008	2	448
		_	Registrar	H- 1 0		Cer	rtificate	OI I	Jeam	12	Date of De	Reg. No). L	, 00		ne of Death
	Physici /Medic		1. Decedent's Name (First, Midd	LANG	·				_	51	Month	IS	_ 2	Year	3. 1111	341 M
	Examir	er	4a. Facility Name (If not institution				4b. City, To		Location of D			1	,	of Death	1.1	
. (C			Severna Park				All males d		verna				nne	Arund		nto or Foreign
	Funeral Director		5. Social Security Number 213–26–1941	6. Sex 7. A	ge (In yrs. Ia 78	st birthday) Yrs.	If Under 1 Months [Days	If Under 24 Hours	Min. Au	Date of Bi (Month, D 1g 30	nun Pay, Year 19	y, Year) 1929 Maryland			l
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							10	Od. Insid	de City Limits
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	th wi	la l	24 Truckhouse	Road				2	1146					SA		
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 💆 Mar	12, Was Deceden Armed Forces 1 XYes 2	?		Was Deceder f Yes, specify 1 □Yes 2		ispanic Origin in, Mexican, P Specify:	? (Speci uerto Ric	ty Yes <i>o</i> r N can, etc.)	0-	Bla	ce - Americ ck, White, e	an India etc. ite	ın,
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21215-0036	in 72 ho n "natul Nedical	Completed by		nt's Education est grade completed)	.5.)	(Give	dent's Usual (kind of work DO NOT use	done i	during most of	working		16b.	Kind of B	usiness/Inc	dustry	unk
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b	offled other vent, I	Be C	17. Father's Name (First, Middle,	, Last)					18. Mother's	Name (/	irst, Middl	e, Maide	n Surnar	ne)		
<u>lar</u>	ould be f Mental arked o	10 E	Roy Lang						There	sa I	eona	Ligh	ntmai	n.		
Maryland	nd 2 should be filed withir alth and Mental Hygiene. 27 Is marked other than ir traumatic event, Itsa M		19a. Informant's Name/Relations Betty Lang/spe				Mailing Address (Street and Number or Rural Route Number, C 2 Old Magothy Bridge Road Pa							.122		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Everniner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (CO	ace of Dispo metery, crer	sition (Name natory or othe	of er plac	re)	Dat	е	20c.	Location	- City or To	wn, Sta	te
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8760,	eath certificate be executed attending physician and for use as the burial-transit	ical	that initiated events resulting in death) Last	c. Due to (or a	s e consequ	ence of):										
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ds, P.	ires that signed b	þ	Part II. Other significant condit	*	but not resul	lting in the u	nderlying cau	se giv	en in Part I.							e of death?
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Ξ	nysicia nis cert directo	Be	examiner?	Hospital:	tiont OF	=P/Outpatio	nt 3 DOA	Oth	er: 4 Deliver				6 DO	ther (Speci	4.)	
on of	ding Phy h. After this funeral d	ion: To	27. Manner of Death 1 ☑ Natural 5 ☑ Pendi	28a. Date of Ir (Month, L	jury	28b. Time o Injury		. Injui	y at k?	28	d. Describ				19)	
Division	or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could	minor Zoe, Place of I	njury - At h <i>o</i> r etc. <i>(Specify</i>	me, farm, str		_	Yes 2□No		f. Location City or T	(Street own, Sta	and Num	iber or Run	al Route	e Number,
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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

2422

PASA PENA MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURVIN MUNDA MD 802 | RITCHIE HWY

32. Registrar's Signature

08-05325 Paul Littel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

IUI LITTEI		State of Maryland / Department of Certificate of State			200	8 2448
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 1		3. Time of Death
ledical Examir	ner	Paul Littel		Month Da July 11, 2008		1754 hrs
A teg		4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	7/1	5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 1 7 70 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min.		COL	hplace (State or Foreign untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
		MD Baltimo				1 X Yes 2 No
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
h the N		22 S. Athol Avenue	21229		USA	and Indian Block
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? unk If Ye	Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 \(\frac{X}{A} \) No specify:	Rican, etc.)	White, etc.	ican Indian, Black,
urs afte	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind of	work done Ink	6b. Kind of Business/	Industry unk
036 ithin 72 hou ne. r than "nat ledical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk	ost of working life. DO NOT use reti			
D 21215-003 should be filed withi and Mental Hygiene. 7 is marked other th natic event, the Med		17. Father's Name (First, Middle, Last)	UIIK 18.Mother's Name	e (First, Middle, Mai	den Surname)	ünk
2121: 2121: Mental I. marked c event,	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or	Rural Route Numbe	r, City or Town, State	e, Zip Code)
O € E ≈ #			Penn Street Ba	ltimore,	MD 21201	To an Olean
ore, MC es 1 and 2 si of Health au If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposic crematory or oth	ition (Name of cemetery, ner place)	Date 2	20c. Location - City or	Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		4 Donation 5 Other Specify in State	ame and Address of Facility			
Balt permit, Depart Impor injury			ame and Address of Facility ate Anatomy Boar			Street
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/Medical_ xaminer	9	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
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ox 68760, eath certificate be ex- attending physician for use as the burial-	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
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ords, P.C. w requires that is been signed I should be deta	ted 1	Chronic obstructive pulmonary disease; Hypertension; Obes	sity	24a. Was an	24b. Were a	autopsy findings available
Records, The law require	Completed			autopsy perform	ned? death?	
of Vital Rec ling Physician: The I After this certificate I funeral director, page	e Col	25. Was case referred to medical	26.Place of Death (Chec		_ NO I V	ies 2 10
Vita nysicia this cer I direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient			Residence 6 Oth	er:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury Jul (Month) Daw Year) 111, 2008 28b. Time of Interpretation 1650 hrs	1 Yes 2 ✓ No	Unknown	ow injury occurred	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) Nursing Home		or Town, Sta 22 South Athol	ate) Avenue, Baltimore	
o the Hose within 24 ho o the Fun	edical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investiga and manner stated.	rred at the time, date and place, ar tion, in my opinion, death occurred	nd due to the cause I at the time, date a	nd place, and due to	the cause(s)
F # F O	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (N	Ionth, Day, Year)
		Carol Halldu	O.C.M.E.		July 12, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 212	.01		
	tate	11 11 0 A 2000 Right	100			
Regis DHMH 17 Rev 1/2		OCME ORIGINA	AL			
DELIVER 1 / INCV 1/2	001	ONGINE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23e per doc 8882 8-5-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:27 AM Year Physician Month 2008 Martin A. Lang 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 21 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Baltimore, Maryland 219 01 0989 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland Baltimore City Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 2903 Edison Highway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No 2 Specify: 3XXWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If Item 27 is marked other the any injury or other traumatic event, the once. Service Writer Brookland Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfonse John Lang Agnes Margaret Rhode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Rostkowski (Daughter) 1408 Clearview Road Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. July 28, 2008 Baltimore, Maryland 21. Smature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** aumonia /Medical Due to (or as a consequence of): Examiner Colon Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse mence of To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by + Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ပ 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wor / Hardon 17.10 26,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

CEORGES

31. Date filed (Month, Day, Year)

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2008

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EMORIAL HOSPITA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:25 PM Jul 22, 2008 Raymond Frank Latall 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Highland 7425 Bucks Haven Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 79 Apr 24, 1929 322-24-6958 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Highland Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director:

2	7425 Bucks Haven La	ne		20	777				
by rundial D	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	23/1947	s Decedent of Hispanic Ories, specify Cuban, Mexical	gin? (Specify Yes or N h, Puerto Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, /hite, etc. White		
ובוכר	15. Decedent's Ed (Specify only highest grad	de completed)	(Give kin	t's Usual Occupation d of work done during mos NOT use retired)	t of working	16b. Kind of Business/Industry			
combiered by	Elementary/Secondary (0-12)	College (1-4or 5+)		Lt. Color	nel	Military			
	17. Father's Name (First, Middle, Last)	Raymond F. Latal	I	18. Mothe	er's Name <i>(First, Middle</i>	e, Maiden Surname) Bernadine Ha	hn		
	19a. Informant's Name/Relationship (7	,		Address (Street and Number Bucks Haven La			e, Zip Code)		
	20a. Method of Disposition Mail Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition Cemetery, cremate		Date Aug 21, 200	20c. Location - City	or Town, State		
	21. Signature of Funeral Service Licen		Y	ame and Address of Facili		tt City, MD 2104	3		
	23a. Part 1. Anter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each live. a	pho.	he mode of dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death		
medical Evaluation	Sequentially list conditions, if any, leading to immediate cause. Enter Underwin, Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.							
y Signatura	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 □Ed	stopic pregnancy ther (specify)		23d. Date of Month	delivery Day Year		
	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the unde	rlying cause given in Part			te to the cause of death? Probably 4 □Unknown		
and more					24a. Wa aut per 1∐ Yes	opsy prior formed? deat			
	25. Was case referred to medical examiner?				e of Death (Check only	one)			
2	1 ☐ Yes 2 No		ER/Outpatient		ursing Home 5 Re		Specify)		
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐		e how injury occurred			
Columbat	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, street y)	, factory, office	(Street and Number o own, State)	r Rural Route Number,			
מונטו		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
-	29b. Signature and title of certifier	1 /		29c. License number		29d. Date signed (A	fonth, Day, Year)		

DHMH 17 Rev 1/2001

State Registrar Name and address of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		e of Marylan		rtment tificate			and M	Re	ig. No.	800		+92
	Physic	ian	Decedent's Name (First, Mide	,							July 19	h Day	Year	3. Time of	
	/Medi	cal	Mary W. Muss		d sumbork		4h Cih. T	Four or	Location o	f Donth	July 19		inty of Death	4:05	PMW
1	Exami	ner	419 Hoyes Sa	-					ville	ii U u atii		Garr	•		
Н	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Birth			place (State ontry)	r Foreign
	Director		198-30-7331	1 □ M 2 🔀	F 68	Yrs.	Months	Days	Hours	Min.	(Month, Day, Aug 18,	1939		sylvan	
	pur k		Usual Residence of Decedent 10a. State 10b. Count		10c Cib	, Town or Lo	nation							10d. Inside Ci	by Limite
	the Marylar 28a-f show	5		, rrett		riends								1 ☐ Yes	-
	the Maryla 28a-f shoo	ect	10e. Street and Number				10f. Zip (Code			1	0a Citizen	of What Cou		Λ.
		Ō	419 Hoyes San	g Run Ro	ad		10.1.2		21	531			USA		
		Completed by Funeral Director	11. Marital Status	12. Was	Decedent Ever in U.	S. 13. \	Vas Decede	ent of Hi			ecify Yes or No- Rican, etc.)		Race · Ameri		
9	after or Ite	Full	1 Never Married 2 Ma	rried 1 TY	d Forces? /es 2 No s, Give	i	r Yes, speci I∐ Yes 2		n, mexican Specify:	, Pueno	Hican, etc.)		Black, White, ec <i>ity:</i> WÎ	etc. nite	
5-0036	72 hours after "natural", or Ite	d b	3X Widowed 4 ☐ Divorce	d Year	or Dates:										
15-	nati	lete	15. Decede (Specify only high	nt's Education est grade comple	ted)	16a. Deced	lent's Usual kind of worl DO NOT use	l Occupa k done d	ition <i>Juring m</i> osi	of works	ng	16b. Kind o	f Business/Ir	idustry	
2121	withii then	J mo	Elementary/Secondary (0-12)		ge (1-4or 5+)	me. i		sewi				OWI	n home		
b	filed Hyg other	Be C	17. Father's Name (First, Middle	, Last)						r's Name	(First, Middle, I				
lar	should be filed within : and Mental Hygiene. • marked other then "I umatic event, I've Med	ToB							Fr	ance	s Burnh	am			
Maryland	2 sho s and l is ma		19a. Informant's Name/Relation Sharon Bowman								d Route Number ad Frien				1
	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: If Item 27 is marked other then "any injury or other traumatic event, the Manance."		20a. Method of Disposition			lace of Dispo			g Kun				on - City or T		1
Baltimore,			1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other	Specify)	1 0	emetery, cren	natory or oti	her place	9)			EUG. EUGAN	on one of	own, oluto	
Ball	permit. Peg Department Important: any injury o		21. Signatura Funeral Survice	S. Wade,	Director		Name and tate altim		_	Boar 212	d 655 W. 01	Balt	imore	Street	7
1	Physician		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complications that to only one cause	on each line.	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximat Interval Bet Onset and	ween
1	/Medical Examiner		resulting in death)	Du	e to (or as a consequ	uence of):	110	01-	h .					2	•.
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Que	e to (or as a consequ	Jence of):	190	u.	iws					391	
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ő	e exerien ar urial-t	EX	resulting in death) Last	Du	e to (or as a consequ	171-								~ J	C .
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9 X	ding g	/Med	IF FEMALE:	23c If yes	, outcome of pregna	ncv						004	Data of data		
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1□L 4□P	ive birth 2 Fetal regnant at time of de Inknown	death 3	Ectopic pre Other (spe					230.	Date of deliv Month	-	Year
of Vital Records, P	quires that in signed t uld be deti	6	Part II. Other significant condit	ions contributing	to death but not resu	ulting in the ur	nderlying ca	use give	en in Part I.		23e. Did tol			the cause of d	
တ္တ	aw requir ss been si 2 should	Completed									24a. Was a		b. Were aut	opsy findings	available
ĕ	The lay ate hes page 2	ĕ									autops perform	ned? ☑ No	death?	2ĺ ⊠ ŠNo	ause of
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medic examiner?							of Death	(Check only on	-			
=	Physic this c	မ	1 ☐ Yes 2 No			ER/Outpatien			4 🗀 Nu		me 5 Reside			<i>(y)</i>	
n C	ding P. h. After	on	27. Manner of Death 1 XNatural 5 ☐ Pend		Nate of Injury Month, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury oc	curred		
Division	death ctor: y the	icat	3 Suicide 6 □ Could		Place of Injury - At ho	me farm str	M est factory		res 2□i	NO	28f Location (St	reet and Ni	umher or Rui	al Route Nun	nher
Div	after after Dire	Certification:	4 ☐ Homicide deter	mined 289. P	uilding, etc. (Specify	<i>')</i>	oot, tactory,	, onlog			City or Town		ambor or riar	ar ribbio ribir	7001,
	To the Hospitel or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certify (Check only 2 Medica	I Exeminer: On the	o the best of my know he basis of examinat manner stated.	wiedge, death tion and/or in	occurred a restigation,	at the tim	e, date an pinion, dea	d place, th occurr	and due to the c ed at the time, d	ause(s) and ate and pla	manner as ce, and due	stated. to the cause(s	s)
	To the within To the compl	Me	29b. Signature and title of certifi		1		29c.	License	number		2	9d. Date si	gned (Month	Day, Year)	
			Sechaenh	at No	anialoj		D	584	55			712	3121	200	
			30. Name and address of person	who completed	cause of death (Item	23a) (Type,		_			_		-	21:	536
			Sabaha-	- Na	wab	3:	2 (٥	POF	-a+	e Di	-, G	rant	sville	e Ma
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 8:13AM FRANK MACCIA EMENT 2000 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPICE BALTIMORE STELLA MARIS TIMONIUM 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) NEW VERSEY 6. Sex M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days 139 20 849 Director Usual Residence of Decedent 10h County 10c. City, Town or Location show 10a State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ite Micrical Examiner must be notified at Director tXÎYes 2 □ No CARROLL min ELNERS BURG 10e. Street and Number 10g. Citizen of What Country? USA Funeral LOCUST 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1946 -If Yes, Give Year or Dates: 1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 1952 Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. 7 is marked other than "n. DIERLESS Elementary/Secondary (0-12) College (1-4or 5+) OF OPERATIONS IMPORTERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MACCIA TERENGHI ANGELINA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra once. FRANK 85 MACCIA WHITE ROCK ROAD ELDERSBURGMO altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 8/1/2008 ST GERTNUDES CEM 4 Donation 5 Dother (Specify) Colonia, N.J. 22. Name and Address of Facility IN ZUMBRUN FH & MON CO. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the clasease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliure. List only one cause on each line. 6028 SYKESVILLE RU ELDERS BURG-MO2178 Approximate Interval Between Immediate Cause (Final **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a py leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consequence of): be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 □ Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 In Nursing Home 5 In Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 X Natural 5 ☐ Pending investigation 124 hours after death.

le Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/dr investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 200 52740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. ERNESTINE WRIGHT TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State JUL 3 0 Registrar

DHMH 17 Rev 1/2001

CLEMENT MACCIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 335 A M 25 2008 David Francis Magee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN Square Hospital Center Rosedale Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days Months 05/16/1944 MD Director 216-40-1647 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinating using a notified at 1 ☐Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21237 USA 4815 Ridge Rd. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No "natural", or Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Wholesale Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Hardware <u>Project Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Anne Burkhardt David Francis Magee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other terms 4815 Ridge Rd. Balt. MD, <u>Charlotte Ann Leake/Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crem. 2008 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility WOLYY CAFA/Stephen D. Lohrmann P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr. Towson, MD, 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxia

Die o (or as a consequence of): /Medical Examiner OF UNKNOWN OFGIN INVOlVING LUNG LIVE Small Cell CA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. | 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 00066750 MD

State Registrar Juan

31. Date filed (Month

Sauare DR. Balto, md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 0

J. Rivera Year)

9000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0520 HM David Hamilton McGinty 200 Juli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 54 07.23.2008 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 25 No Director PA Dauphin Harrisburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 5209 Woodlawn Dr. 17109 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status n/a within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced 27 is marked other than "natural", traumatic event, the Medical Exal Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ 2 should be fi and Mental F permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev <u>Ann Pagiass</u>otti Aaron McGinty Maura ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5209 Woodlawn Dr., Harrisburg, PA 17109 Aaron McGinty/Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 07.28.08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Dr. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or lea c nsequence of): Physician disease or condition /Medical resulting in death) Examiner chydram nio Olig Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and I for use as the burial-transit Prematurit Due to (or as a consequence of): Box 68760. Physician/Medical certificate be IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the average 2 should be detached to 1 Yes 2 9 Unknown 2 🗌 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Division of Vital Records, 2 No 1 Tes 3 🗌 Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 □ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 2 No 1 Depatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ After this completely filled in by the funeral 27. Manyer of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day 5 Pending investigation 1 Tes 2 No death. 2 Accident hours after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person (who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

000675

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24496 State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18^{pay} Physician 2008 July 2:34 P M Joseph James Merryman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Maryland General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/21/1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months MD 219-32-9841 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1XYes 2 □ No or other traumatic event, the Medical Examiner must be notified Director MD Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21230 USA 1722 Christian St. "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20 No Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeneice Unknown Robert Merryman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sean Merryman/Son permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai 2624 Loloya South Way Balt. MD, 21215 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 22, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CAFA/Stephen D. Lohrmann P.A MD 21286 8717 Green Pastures Dr. Towson, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physician and I be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manufer of Death Certification: 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07-25-08

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Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MIITCHELL 21,30P M 28, 2008 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N 1A BALTIMORE AGNES HOSPITAL SAINT Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** Days 1 ☐ M 2 🗷 F Director a Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner, ust be nothlied at 1 ☐ Yes 24 No Funeral Director paltimor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe KO 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) ministrative ASSISIAMI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ntai is marked o s ones rnestine Ernest ၉ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>.s</u> Huskan Catonsville, m.D. of Health of Item 27 is Ridge Rd. 21228 Mitchell 0 outh Ja mes Baltimore, tem 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State atonsville renatoxy Aug. 2, 2008 4 ☐ Donation 5 ☐ Other (Specify) 270 FredHILTON 22. Name and Address of Facility 21. Signature of Funeral Service License march F.H. Baltoind. 23a. P.n.1. Envir the disease, or complications that caused the death. Do not enter the male of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical the Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown FAILURE page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CONGESTIVE HEART FAILURE or Attending Physician: The law 2 No 1 ☐ Yes 1 ☐ Yes Vital Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of Date of Injury (Month, Day, Year) 27. Mannet of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P20656 JULY 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONSTANTIN ZUBELEVITSKIY 900 CATON AVE. BALTIMORE MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Jüly 26 2008 **Physician** 8:10pm M Emil Melde /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 € M 2 □ F 220 34 7329 69 July 9 1939 Baltimore, MD. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Ren az 71 s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medica E. ac. in an its in titled. 1 ☐ Yes 2 ☑ No Director Jarrettsville Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21084 USA 1915 Trout Farm Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1959 -1961 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Enterprize Electric Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meta Marta Ristow Curt E Melde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21236 9413 Perry Hall Blvd. Sandra M Baum (Sister) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 30 2008 Baltimore, Maryland <u>Metro Crematory Inc</u> e of Funeral Service License 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore Maryland 21236 Part 1. Enter the disease, or or in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TIPL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop. performed 2 M certificate 1 Yes 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ၉ this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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m 23a) (Type, Print)

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AMEN TIP #18 perf H 682.8 1/08 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 24499 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year JMPIN 25 2008 **Physician** William John Marck Jr 2:45 pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford County 231 East Belcrest Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Year, August 23 1924 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months Baltimore, Maryland 1□M 2□ F Yrs. 219 18 3242 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medical Evention that by nutting at 1 ☐ Yes 2 ☐ No Director Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 LISA 231 East Belcrest Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XXXVio Specify. Specify. Completed by WW II White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 8 Elementary/Secondary (0-12) Baltimore County Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty William John Marck Sr Thaver ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Important: If item 27 is
any injury or other trau 11311 Notch Cliff Road Glenarm, Maryland 21057 John T Marck (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland St Demetrius Ch. Cem. July 29, 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EF Lassahn Funeral Home PA 21. Signature of Funeral Service Licenses D. 11750 Belair Road Kingsville, Md. 21087 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KIDNEY **Physician** FAILURE disease or condition resulting in death) /Medical Due to (or as e consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnency
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day the detached 9 Unknown á signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð CONGESTIVE 1 des 2 No 3 Probably 4 Unknown Completed OBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t 24a. Was an autopsy certificate 2 🗆 No 1 ☐Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D08096 JULY 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULFORD AVE BELAND, MD 2014

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32. degistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year 4:30 PMM Gretchen A. Osgood /Medical July 20, 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5502 Park St. Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F 86 Director 477-20-8488 07/23/1921 OH Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Wedical Examinar must be notified at Director 1 ☐ Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5502 Park St. 20815-Funeral United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: 3 M Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 'ealth and Mental Hygiene.' m 27 Is marked other than " Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Deputy Director of Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Keri Anderson ပ Clara Hazel Abell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Bonnie S. Wilson/Friend 5345Falmouth Rd. Bethesda, MD 20814permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Jul 26 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2008 21. Signature of Funeral Service License 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services Rapp Funeral & Cremation Serv 933 Gist Ave. Silver Spring.

23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a CARDWPULMONARY MMCO, ATZ /Medical Due to (or as a consequence of): **Examiner** ASTIN ESOPHAGEAL 1 DAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of sician and burlal-transit Physician: The law requires that the death certificate be executed PULLMUNAMES HOUNIC CHATRIDAVE Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: Certification: To ð 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of To the Hospital or Attending i within 24 hours after death.

To the Funeral Director: After 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number D 0034742

State Registrar ANDREW

31. Date filed (Month, Day, Year)

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eath (Item 23a) (Type, Print) #348, WASHINGTON DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature